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ABSTRACT

This document presents findings from a study conducted to examine the relationships between jails which were represented at the 1978 Special National Workshop on Mental Health Services in Local Jails and the various components of their local mental health systems. Chapter I explains the origins and scope of the study, describes the sample of 33 jails located in 26 states and methods of data collection, and provides an overview of monograph goals. Chapter II presents a distillation and review of current standards for jail mental health services as promulgated by different professional associations. Chapter III describes mental health services that were available in study sites at the time of initial field work. Four distinctive approaches to service delivery are identified and capsule profiles of each type are included. Chapter IV analyzes responses to survey questions dealing with the perceived effectiveness of various organizational arrangements for providing inmate mental health services on study sites. Chapter V focuses on the frequency and scope of staff conflict among mental health and correctional personnel in study sites. Chapter VI addresses subsequent developments and changes made at study sites in the 12 to 18 months following initial site visits. Chapter VII presents a summary and conclusions concerning study findings and their implications for mental health program planning for local jails. Lists of references, cases cited, and participating sites are included. (NB)

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Developing Jail Mental Health Services: Practice and Principles

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Developing Jail Mental Health Services: Practice and Principles

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Public Health Service
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DEVELOPING JAIL MENTAL HEALTH SERVICES: PRACTICE AND PRINCIPLES

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FOREWORD

Many policy changes at the interface of the legal and mental health systems have had an impact on local jails in the past quarter of a century. The deinstitutionalization of State mental hospitals, the use of more restrictive civil commitment standards, and the issuance of court-ordered minimum standards for medical and mental health services are illustrative of these far-reaching developments. Yet little empirical research has been carried out on the short- and long-term effects of these changes on local jail operations. It is unclear, for example, whether these changes have led to significant increases in the number of mentally disordered persons confined in local jails (although this does not appear to be the case in many instances) or whether they have simply fostered a greater awareness of what was already a long-standing problem. Nevertheless, the available data on prevelance rates of severe mental disorders in local jails clearly suggest that mentally ill inmates constitute a significant population in need of mental health services.

Even though the provision of mental health services to jail inmates is a critical need, little research has been conducted on the structure and operation of existing jail and mental health interfaces in the United States. As an unfortunate consequence, very little is known about alternative ways to deliver jail mental health services and their comparative advantages and disadvantages. This monograph, which reports on research undertaken to develop an information base on current practices in jail mental health services, is an effort to address this glaring need.

Following the first "Special National Workshop on Mental Health Services in Local Jails" sponsored by three Federal agencies and held in September 1978, Dr. Henry Steadman and his colleagues at the New York State Office of Mental Health examined the relationships among the jails represented at the conference and the various components of their local mental health systems; this study was supported by a research grant from the National Institute of Mental Health. By employing an interorganizational framework, the study was specifically designed to delineate the range of approaches followed by these jails in developing mental health services for inmates, the availability and extent of linkages with community mental health services, the relative effectiveness of the identified program approaches, and the

factors that seemed to influence and sustain program development.

We are pleased to make this monograph available to a wide audience of mental health and correctional administrators, program planners, and policymakers, and hope that it will provide useful information as well as aid in the delivery of improved mental health services to jail inmates.

I would also like to express sincere appreciation and thanks to the jail and local mental health facility staffs who participated in this study.

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Chief, Antisocial and Violent
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PREFACE

Our research interest in jail mental health services was sparked by a workshop on jails held in Baltimore in 1978 and sponsored by the National Institute of Mental Health (NIMH), the National Institute of Corrections (NIC), and the National Institute of Law Enforcement and Criminal Justice (now the Institute of Justice) (Dunn and Steadman 1982). The workshop prompted us to turn our attention to the serious problems of providing mental health services for jail inmates We were struck by the virtual absence of any empirically grounded guidelines for establishing appropriate services for this population. As a consequence, the research later undertaken with grant support from NIMH and described in this monograph was designed to study the relationships among the jails represented at the workshop and the various components of their mental health systems. Our goal was to produce an information base on current mental health service practices that could be used to distill a set of principles for program design.

During the conduct of this research, we received enthusiastic responses from the administrators and mental health staffs at every jail selected for study. In fact, their participation was 100 percent. During the site visits, people were exceedingly cooperative, open in their observations, and gracious in giving their time for our interviews.

While we would like to extend our appreciation to everyone who participated in the study, several jail staff members warrant special note. Joseph Evers of the Clark County (Nevada) Jail allowed us to visit his program on three separate occasions. For our third visit he organized an interdisciplinary group that provided us with important feedback on our initial research observations. Marion Goodman of the Contra Costa County (California) Mental Health Department provided helpful assistance at a number of junctures in the project. Although not affiliated with any of the 43 jails in our study, she set up an informal site visit that opened our eyes to some of the best programming we saw, pilot-tested our mail survey instrument, and arranged for staff members to meet with us to review our initial formulation of planning principles. Richard Warner and his mental health staff at the Boulder County (Colorado) Jail also provided informed critiques of our preliminary results. These are just a few of the hundreds of people who extended their

friendship and informed opinions to us during our 43 site visits.

The success of our work owes much to three research associates who helped develop the congenial onsite relationships. Harold Kilburn, Nancy Elliot Sampson, and C. Lee Scott are skilled interviewers and consummate professionals. They contributed to all phases of the research, from instrumentation through coding and analysis to write-up. That the same talented staff started and finished the fieldwork phase of the project was a major factor in the thoroughness of the work and its timely completion within budget. Michael Lindsey and Pamela Clark Robbins also participated in the analysis and write-up of project findings.

We would also like to acknowledge the contribution of several staff members of the Antisocial and Violent Behavior Branch of NIMH whose support, encouragement, and helpful suggestions were invaluable to us both in the conduct of the study and in the development of this monograph. Christopher Dunn helped focus our attention on some of the more serious problems in providing mental health services to jail inmates, and Saleem Shah, chief of the branch, provided important guidance in the mental health policy issues in this area. Finally, we owe a special debt to Ecford Voit whose skillful editing of our overly technical draft manuscript enhanced the substance as well as the clarity and readability of this volume.

Our hope is that this foray into the complex, often frustrating, and depressing world of mental health services for jail inmates will generate further investigations. This is an area demanding serious attention from the public, legislators, mental health professionals, correctional administrators, and researchers. It involves many human beings whose coping skills are exhausted by the strain of incarceration. They include not only felons convicted of multiple charges and long-term substance abusers but also former mental patients, the economically disadvantaged, and white-collar drunk drivers. The community has obligations to these people while their liberty is being restricted. This monograph attempts to provide some concrete guidelines on how to develop appropriate programmatic responses. However, although we can provide guidance, it is the reader who must provide the action which we hope we have facilitated by this report.

CHAPTER I

THE JAIL IN A POST-DEINSTITUTIONALIZATION ERA

Administrators of local jails are in the midst of a crisis that threatens virtually the entire range of jail operations. Conditions in most of these facilities have always been poor, but the situation has become acute in many jurisdictions. Nearly half of the jails in the United States are over 30 years old (New jails 1981). Extensive renovations are needed at many facilities just to meet minimal State standards. Some sheriffs are refusing to accept new prisoners because their jails are already operating far in excess of rated capacity (Carney 1982), and public attitudes have made it difficult to obtain funding for needed services. Conditions are so bad that both State and Federal courts are intervening to order sweeping changes in jail operations despite the conservative judicial standard for such cases established by the Supreme Court in Bell v. Wolfish (1979).[1] Officials estimate that from 11 percent (Kerle and Ford 1982) to 33 percent (National Association of Counties 1982) of all jails are under a court order or consent decree as a result of constitutionally deficient procedures and/or programming.

Within this context, the availability of mental health and other types of human services for inmates of local jails has become a major concern for professional and citizens groups over the past decade (Newman and Price 1977a, 1977b; General Accounting Office 1980; Morgan 1981; Dunn and Steadman 1982). In 1978 there were 3,493 jails in the United States, ranging from one- or two-person rural jails to

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[1] In Bell v. Wolfish, 441 U.S. 520, 570 (1979), the Supreme Court accelerated the trend toward a presumptive validity of prior regulations and thereby assumed a hands-off posture with respect to most correctional practices. The Court noted that while constitutional rights must be scrupulously observed, "the inquiry of federal courts into prison management must be limited to the issue of whether a particular system violates any prohibition of the Constitution.... The wide range of 'judgment calls' that meet constitutional and statutory requirements are confided to officials outside of the Judicial Branch of Government."

metropolitan complexes with upward of 5,000 inmates (National Institute of Justice 1980). Most jails are county or municipal facilities that operate as short-term, pretrial holding units for the courts and as detention units for offenders serving sentences of less than 1 year. Traditionally, given the rapid turnover of inmates and a mandate primarily for safe retention until criminal disposition, jail authorities and county fiscal officers have not defined mental health services as a jail responsibility. Inmates with serious psychiatric and behavioral problems were transferred to State mental hospitals, which were used as primary service providers. Other agencies were expected to deal with the mental health problems of inmates after their release to the community. Crisis intervention services were available in the jails only for some of the most acutely suicidal or "bizarre" inmates; these services usually took the form of physician-prescribed psychotropic medications. Jail was seen as a major provider of mental health services in only a few instances.

Beginning in the early 1970s, however, far-reaching reforms of the mental health, legal, and criminal justice systems markedly altered the social context surrounding jail operations. The rapid deinstitutionalization of State mental hospitals, for example, led to the release of thousands of mental patients to community settings (Bachrach 1976; Bassuk and Gerson 1978; Morrissey 1982b). A number of reports later indicated that many of these patients were arrested and incarcerated in local jails on misdemeanor charges as a way of dealing with their disturbed behavior (Abrahamson 1972; Zitrin et al. 1976; Whitmer 1980; Lamb and Grant 1982). While such actions may, in part, have been a consequence of civil libertarian reforms that led to the imposition of much more stringent standards for involuntary commitment and to a corollary reduction in State mental hospital beds (Robitscher 1976), the effects of these changes were to significantly curtail admissions to State mental hospitals (Morrissey and Tessler 1982) and to make transfers to these facilities much more difficult to accomplish.

The courts have also directly intervened on behalf of inmates in local jails. Class action suits in cities such as Pittsburgh, Pennsylvania; Phoenix, Arizona; Las Vegas, Nevada; and Washington, D.C., have resulted in court-imposed minimum medical and mental health services (Morgan 1981; Singer 1981). While it is still unclear whether these developments have led to a dramatic increase in the

number of mentally disturbed inmates in local jails (Steadman and Ribner 1980) or simply heightened the awareness of what has been a long-term problem, there was a concomitant 12 percent increase in the number of inmates being held in municipal and county jails from 1972 to 1978 (U.S. Department of Justice 1980b). Thus even if the proportion of inmates with mental health problems had remained constant, there would still have been an increase in the absolute number of prisoners needing professional care. Consequently, jail officials would probably have become more aware of the need for mental health services even if the number of State hospital beds had not been reduced during these years.

Despite these developments, there are no comprehensive national data on the scope and level of diagnosed mental health needs in local jails. However, Monahan and Steadman (1982), in a recent review of the available literature, found six studies that investigated true prevalence rates of mental disorders among jail inmates in particular jurisdictions:

- Arthur Bolton Associates (1976) surveyed more than 1,000 adult offenders in five California county jails and reported that 6.7 percent of the inmates were psychotic, 9.3 percent had a non-psychotic mental disorder, and 21.0 percent had a form of "personality disorder."

- Swank and Winer (1976) assessed 100 consecutive admissions to the Denver County (Colorado) Jail and reported that 5 percent were psychotic, 13 percent had "antisocial personalities," and 16 percent had "other personality disorders."

- Schuckit (1977) interviewed a random sample of 199 white men (whose major charge was not drug related) shortly after their admission to San Diego (California) County Jail. Three percent of these inmates had a psychotic affective disorder and 3 percent had an organic brain syndrome. "Antisocial personality" was diagnosed for 16 percent of the inmates, alcoholism for 15 percent, and drug abuse for 12 percent.

- Bogira (1981) reported that 4 percent of the inmates in the Cook County (Chicago) Jail were

classified as "psychotic, suicidal, or in a serious manic depressive or toxic state" or "had serious adjustment problems."

- O'Keefe (1980) studied 955 inmates in three county jails in Massachusetts and found that 4.6 percent of the jail admissions were sufficiently mentally ill to be civilly committed by a psychiatrist; an additional 6.2 percent "were noted as exhibiting signs of mental illness by jail personnel" but were not committable.

- The 1978 National Jail Survey of the U.S. Department of Justice (DOJ 1980b) sampled 5,172 inmates in jails throughout the country (94 percent male), who were asked whether they were experiencing a "nervous disorder," a "mental problem," an "emotional problem," or "depression." Although no definition of terms was provided, the data showed that 4.1 percent of the men and 6.4 percent of the women reported a nervous disorder, 1.6 percent of the men and 2.2 percent of the women reported an emotional problem, and 1.1 percent of the men and 2.4 percent of the women reported depression.

These studies indicate that the true prevalence rate of severe mental disorders (i.e., psychoses) in local jails ranges from 1 percent to 7 percent, and the rate for less severe forms of mental illness (i.e., nonpsychotic and personality disorders) varies greatly, ranging up to 20 percent (Roth 1980). Citing community prevalence rates reported by Neugebauer et al. (1980), Monahan and Steadman (1983) concluded tnat "the weight of the evidence appears to support the assertion that the true prevalence rate of psychosis among the inmate population does not exceed the true prevalence rate of psychosis among class-matched community populations." Nonetheless, given the deficit of mental health services in most jails, these data also suggest that mentally ill inmates constitute a significant population in need of such services.

If current legal and mental health policy trends continue, all but the smallest jails will have to contend with the prospect of developing mental health services to safeguard the constitutional rights of their mentally ill inmates. However, with the exception of a few expository reports on

individual jails (e.g., Nielsen 1979; Haley 1980; Russel 1980) and descriptions of selected "model" programs (Morgan 1978), the actual structure and operation of mental health services for jail inmates in the United States have not been studied. As a consequence, few insights are now available about alternative ways to deliver mental health services to jail inmates and about their relative advantages and disadvantages. The research on which this monograph is based was designed to address these issues.

Origins and Scope of the Study

The impetus for our research was derived from the Special National Workshop on Mental Health Services in Local Jails, which convened in Baltimore in September 1978. The workshop was organized and jointly sponsored by three Federal agencies--the National Institute of Mental Health (NIMH), the National Institute of Corrections (NIC), and the National Institute of Law Enforcement and Criminal Justice (now the National Institute of Justice). The purposes of the workshop were to define problems and needs, to facilitate the exchange of information between correctional and mental health officials, to develop programmatic considerations, and to provide a framework for changing mental health services in the local jails. Approximately 60 people attended. Delegates included on-line practitioners, legal experts, academics, and representatives from several administrative agencies.

One outgrowth of this workshop was the recommendation that regional followup meetings be held to build on the interest in program development strategies that had been expressed there. In October and December 1979 NIC sponsored three additional workshops that were organized by Carole Morgan of Training Associates, Inc. The workshops were conducted in Hyannis, Massachusetts; Atlanta, Georgia; and Boulder, Colorado. They had three principal objectives: (1) to increase the level of awareness of persons directly responsible for service delivery at each of the participating locations, (2) to achieve a mutual sense of responsibility and commitment for increased program development, and (3) to devise a strategy for each location to further the development of the provision of mental health care in jails. Organizers of the 3-day workshops sought participant teams from all areas of the country that expressed a desire to upgrade jail mental health services. The teams were to consist of three to four persons, including key

decisionmakers, from jails and mental health systems as well as others who were in positions to assist in implementing the strategy for each location.

Shortly after the workshops were concluded, we received a grant from NIMH to study the relationships between the jails that were represented at the workshops and the various components of their local mental health systems. It was hoped that the research would, among other things, delineate the range of approaches these jails followed in developing inmate mental health services, the availability and extent to which linkages were established with existing community mental health services, the relative effectiveness of the various program approaches, and the factors that influenced program development over a 2-year period following the initiation of the study.

Study Sample

The sample chosen for our study included the 33 jails that were represented at the NIC training workshops. Presumably, the administrators of these facilities were concerned with mental health programming and had experimented with a variety of service options. Ten other jails also were selected for inclusion in the study because they were reputed to have model programs or because the courts had recently ordered extensive improvements in existing services. No site had to be eliminated from the proposed sample because jail or mental health officials refused to participate in our research.

The jails were located in 42 communities in 26 States. Nationally, more than 75 percent of all jails are clustered in the southern and north central States (DOJ 1981). The sample jails, by contrast, were drawn about equally from each of the four major regions of the country. Jails in the Northeast have been overrepresented and those in the South underrepresented.

The relationship between the sizes of U.S. jails and the sizes of those in our study sample is a bit more complex. Most jails are very small. Nearly half of all local adult correctional facilities hold fewer than 10 inmates, and Miller (1978) reports that 75 percent hold fewer than 20. Collectively, however, the small jails hold very few inmates; most locally detained persons are incarcerated in large urban jails. The 130 jails with populations in excess of 250 represent

only 4 percent of all jails but hold nearly half (45 percent) of the men and women in custody. Except for one jail system in a southwestern State with an average daily population of 1,575, the jail populations in the sample ranged in size from 15 to 630. While the sample thus contains a disproportionate number of medium-size and large facilities, they comprise more than 70 percent of all inmates in U.S. jails (Goldkamp 1978, p. 24).

Although selected on the basis of different criteria, the workshop and supplemental sites were comparable both in jail size and in geographic spread. At the time data were collected, the workshop jails had an average daily population of 222 inmates. If the one especially large jail is excluded, the average daily population of the comparison jails was 206. The 33 workshop sites were located in 21 States, while the 10 additional sites were in 9 States. (A list of the participating jails can be found in the appendix.)

Data Collection

Each of the 42 sites was visited for 2 or 3 days by a two-person team using a semistructured interview schedule to obtain information about services provided to mentally ill inmates and linkages with community mental health service providers. Descriptors of onsite mental health programs were obtained from the mental health program chief at each jail or from the sheriff where there was no jail program chief. Interviews lasted about 1 hour and focused on the volume and structure of services in eight specific areas that represent a full range of mental health services: intake screening, evaluations, distribution of psychotropic medication, psychological therapy, competency examinations, drug and alcohol counseling, internal or external hospitalization of the acutely mentally ill, and case management at release. Key persons in the external agencies that provided mental health services to the jail, such as community mental health centers (CMHCs) and the forensic units at State mental hospitals, also were interviewed concerning the services they provided.

Following the site visits, a questionnaire was mailed to persons we identified during these visits as being familiar with the jail mental health programs. The questionnaire asked a variety of questions concerning the perceived effectiveness of the programs and the extent of interagency conflict among participating agencies in each county.

Together the information from onsite interviews and the perceived-effectiveness questionnaire provided a way of characterizing study sites at the outset of our research.

The third major data collection activity was a telephone survey of all 43 sites to determine what program changes had occurred in the 12 to 18 months following our initial site visits. This survey involved representatives from the sheriff's department or jail administration at each site as well as one or more informants from external mental health agencies (where relevant). The content of these interviews focused on any changes in the mental health services program, personnel turnover, the initiation of any court litigation, budgetary changes, and any developments in the local community mental health system which impinged on inmate mental health services.

The fourth data collection task involved a resurvey of correctional and mental health staff at each site who responded to the original perceived-effectiveness questionnaire. The original data were collected in a mailed survey in November 1982. This second questionnaire focused on the frequency and scope of day-to-day conflicts between correctional and mental health personnel in each jail mental health program.

The final set of data was generated from 1-day site visits to three jails in January 1984. These data included one of the most comprehensive jail programs we found among the 33 NIC training workshop jails and one of the most rapidly developing mental health programs among the 10 comparison sites. The third jail was not one of the 43 sample sites. This jail served as an NIC Regional Resource Center and was one of the sites where our staff conflict resurvey had been pilot-tested. These site visits provided the opportunity to present our findings and recommendations to knowledgeable correctional and mental health staff. The feedback we received played an important role in the formulation of the principles for program planning presented in chapter VII.

Overview of Monograph Goals

From the outset of our research we were struck by the virtual absence of any empirically grounded guidelines for establishing appropriate services for mentally disturbed inmates in jails and local correctional facilities. From all

indications in the media and professional journals, the problem of the mentally ill in jails was intensifying as a result of changes in the legal, political, and economic environment of the mental health and criminal justice systems. County officials and citizens groups throughout the country, stimulated in part by the threat of court intervention, were confronted with the myriad problems of mounting or improving mental health services for jail inmates. We recognized that a careful and systematic approach to the design and implementation of such service programs would benefit from a thorough needs assessment of the "true" prevalence of mental illness in a large, representative sample of U.S. jails. However, we also knew that epidemiological investigations of this scope and complexity would be extremely costly, difficult to implement, and of such long duration that practical implications for program design would not be immediately forthcoming. Clearly, local officials and service providers could not afford the luxury of deferring service interventions until long-term research findings became available. Rather, to be responsive to immediate needs, a different research strategy was needed.

Consistent with this rationale, we approached our study with a less ambitious but potentially more relevant set of objectives. Our overriding goal was to develop an information base on current practices in the jail mental health services arena from which a set of principles for program design could be distilled. By identifying and assessing the alternative arrangements that local jails have developed to meet the service needs of mentally ill inmates, we felt that guidelines and recommendations could be drawn up to assist those jails that were just beginning to develop local programs or were expanding or enriching their inmate mental health services.

Ideally, a representative sample of jails would also have been useful for such a project to ensure a broad mix of facilities with varying numbers of inmates, resources, and community characteristics. However, as our basic goal was not to describe the current availability of mental health services in the universe of U.S. jails, a more targeted study sample was appropriate and desirable. That is, to identify the various approaches and operational characteristics of mental health programs for jail inmates, only a limited but broad cross section of jails was needed. This reasoning prompted us to focus on the sample of jails that sent representatives to the 1979 NIC workshops and to supplement

this sample with other jails to increase the range of variation on services provided, administrative auspices, and court involvements.

Our subsequent contacts with local providers at professional meetings and a close monitoring of the literature in this field have confirmed our judgment that our sample of 43 jails does encompass the major types of service programs now in existence and is a broad cross section of small and moderate-size facilities. By design, we excluded the "mega-jails" of the type that exist in New York City, Chicago, Los Angeles, and other major metropolitan areas in the United States. These systems of facilities with inmate populations ranging from 4,000 to 8,500 are both quantitatively and qualitatively distinct vis-a-vis the vast majority of U.S. jails. The problems of developing and operating inmate mental health services for these jails warrant separate study. Our research deliberately focused on small and medium-size jails with inmate populations of less than several hundred inmates. Such facilities, as noted earlier, detain the vast majority of inmates in the United States.

Given these overall study goals, our data collection and analysis activities focused on four core questions:

1. What kinds of services currently exist to meet the needs of mentally ill jail inmates? To answer this question, we compiled detailed profiles of the range and mix of mental health services available for jail inmates in each of our study sites. Our interest here was in identifying the variety of practices in our sample that reflect the distinctive approaches to service delivery currently existing in this field.

2. Does the way services are organized make a difference in the operation and perceived effectiveness of jail mental health programs? To answer this question, we classified the mental health programs at each study site in terms of their auspices (jail versus mental health agency) and location (inside versus outside the jail) and surveyed participants about the extent to which the programs were successful in meeting both safety and service goals.

3. How did each of the programs fare during a 12- to 18-month followup period? This question was addressed by conducting a telephone followup at each site to learn about any changes that had occurred in the mental health services provided to jail inmates, developments in the community or State that impinged on the jail program (both positively and negatively), and budgetary cutbacks that had led to the curtailment of inmate mental health services.

4. What are the frequency and scope of staff conflict between mental health and correctional personnel who are involved in the day-to-day operation of the jail mental health service program? The issue of whether there is an enduring conflict between custody and therapy goals in correctional mental health service settings is one that we became aware of during the course of our research. Little research has been done on this issue for local jails. To answer this question, we resurveyed the respondents to our earlier perceived effectiveness questionnaire with a new instrument focused on a variety of the potential day-to day conflicts that might arise in a jail mental health program where close collaboration is required between correctional and mental health professionals.

The remainder of this monograph is devoted to a presentation of our findings with regard to each of these questions and subsidiary issues. In chapter II, as background for a consideration of our study findings, we present a distillation and review of current standards for jail mental health services as promulgated by various professional associations. This review represents one of the most comprehensive assessments of professional standards currently available in the literature. It has value in its own right as a compilation and comparison of current standards and can be read with benefit independent of the remainder of the monograph. Our basic contention is that although service standards are important for ensuring more effective responses to the problems of mentally ill jail inmates, they fail to address many of the practical problems of how the standards can be met in a variety of jail settings. To develop such program design principles, research of the sort we have undertaken is needed.

Chapter III is devoted to our first research question and involves a description of the mental health services that were available in our study sites at the time of our initial fieldwork. We present information about the frequency and mix of services provided by the 43 jails and identify four distinctive approaches to service delivery that were followed by several of the study jails. To illustrate the substance of these approaches, we also present two capsule profiles of each type drawn from our site visits.

Chapter IV addresses our second research question concerning the perceived effectiveness of the various organizational arrangements for providing inmate mental health services in our study sites. We analyze the responses to our initial sample survey concerning the extent to which the auspices and locations of jail mental health services make a difference in the perceived effectiveness and extent of interagency conflict associated with these programs. We also highlight the trade-offs associated with the alternative organizational arrangements for delivering mental health services to jail inmates.

Chapter V focuses on our third research question concerning the frequency and scope of staff conflict among mental health and correctional personnel in our study sites. Our findings are presented in the context of prior research on custody-therapy issues in prisons and mental hospitals and the extent to which findings from this literature can be extrapolated to local jails. As will be seen, there is a consistency in goals between mental health and correctional staff that does not support the inherent staff conflict previously found in prison data.

Chapter VI addresses our fourth research question concerning subsequent developments and changes that impinged on our study sites in the 12 to 18 months following our initial site visits. Findings are presented on changes in staff and service providers; program developments for the small, medium-size, and large jails; changes in specific service components; and the role of court litigation in jail mental health programs.

Chapter VII presents our summary and conclusions concerning study findings and their implications for mental health program planning for local jails. Our recommendations are couched in terms of five basic principles focused on the strategic choices that must be confronted by any

local community in responding to the needs of mentally ill jail inmates. These principles represent a series of conceptual and practical guidelines for developing service programs that can be responsive to the serious human needs associated with the mentally ill in local jails. We have chosen to focus on core principles or guidelines for planning services rather than to isolate a few model programs that could be mirrored elsewhere. Consistent with Bachrach's (1980) observations of the disjuncture between actual, ongoing mental health systems and artificial model programs, we became convinced that immense variations across the nearly 3,500 U.S. jails could be addressed better by adapting basic principles to local circumstances than by simply importing an entire model program. Ultimately, the specification of the five principles proposed in chapter VII could permit any given locality to conceptualize and implement the type of program that best fits its needs and resources.

CHAPTER II

DEVELOPING SERVICES VERSUS GENERATING STANDARDS

Programmatic responses to the needs of mentally ill jail inmates have tended to be segmented and ad hoc. Neither empirical research nor professional associations have developed general models for jail mental health programs. Research has tended to focus on the narrow questions of the incidence of mental disorder in single jails (Petrich 1976; Swank and Winer 1976; Schuckit et al. 1977). Professional associations, reflecting the interests of their members, have concentrated on program standards, usually emphasizing the need for their members to be key providers. The result, as Brodsky (1982, p. 144) has noted, is that jail standards "do not specify the nature or patterns of such service delivery.... The standards do not offer guidelines but rather minimum criteria for program concerns and goals."

The jail administrator, county planning officer, or county mental health director are left adrift when casting about for guidance in developing jail mental health services. Various standards exist, but guidelines for program development are exceedingly scarce. This is not to say that the standards are not useful; rather, it is to say that they provide an inadequate basis for developing the types of services needed to respond to the level of mental health needs in local jails today. The standards may be a useful first step for planners, but they are little more than that.

Our intention in this chapter is to provide an overview of the major jail mental health standards as they exist. Once we have presented them, it will become clear why the field must begin to develop general principles for improving service delivery. The principles gleaned from our research, which may begin to fill this void, are detailed in chapter VII. Before we review the current standards and assess their utility, it may be useful first to clearly define what a jail is.

What Is a Jail?

The U.S. Department of Justice (1980a, p. 1) defines a jail as "a locally administered confinement facility

authorized to hold persons awaiting adjudication and/or those committed after adjudication to serve sentences of one year or less." This definition excludes "drunk tanks" and facilities designed specifically for the detention of juveniles. Also excluded are facilities operated by Federal or State correctional authorities, including State-operated jails in Alaska, Connecticut, Delaware, Hawaii, Rhode Island, and Vermont. Police detention centers, where a person may be held for up to 48 hours following arrest, are also excluded despite articles by Schliefer and Derbyshire (1968) and others which inappropriately use the term "jail" to describe such lockups.

In many respects, the jail is the most important of all our institutions of imprisonment, because two-thirds to three-fourths of all convicted criminals serve their sentences in this type of facility. The jail is also, with rare exceptions, the universal place of detention for untried prisoners and is used on occasion to retain key witnesses, children in need of supervision, mentally ill persons awaiting transfer to a State hospital, parole violators, and any number of other persons who deviate from social norms.

Seventy-four percent of all American jails are run by counties, 22 percent are run by cities, and 4 percent are managed through a joint agreement of both a city and a county. Responsibility for the operation of a county jail is usually assigned to the sheriff. More often than not, the sheriff has a stronger background in policing than in corrections and is primarily concerned with various aspects of law enforcement (patrolling rural areas, investigating crime, executing warrants, etc.). Day-to-day administration of jail management is typically delegated to deputies in all but the smallest jurisdictions.

Unlike long-term prisons, jails have never had a mandate to rehabilitate inmates or to provide substantial programming opportunities. Such an endeavor would be impossible at most sites in any case because of very limited funding and antiquated facilities. As was noted earlier, nearly half of all jails are more than 30 years old (Carter et al. 1975), and 15 percent of the rest have not been renovated in over 15 years (American Correctional Association 1981). The primary function of the jail is simply to detain persons awaiting trial and to incarcerate certain short-term criminals. Therefore, safety and security concerns are necessarily

of paramount importance, with rehabilitation almost never an issue.

The Genesis of Jail Mental Health Standards

Had the States played a greater role in developing and enforcing clear guidelines in the first place, standards from professional associations for jail mental health programs might not have been necessary. Forty-six States have jail standards of some type, but much of the content concerns generic safety and cleanliness requirements that are expected of all public institutions (Henderson et al. 1981). When such standards do address substantive inmate concerns, they tend to be so vague and minimal that their benefit is often open to question. Every State that issues jail standards, for example, mentions medical services, and a few specify that professional staff and an onsite infirmary should be provided at facilities of a particular size. The most common provision, however, states only that medical services be "regularly available" (Buckman 1978).

Whether jailers comply with the most modest State expectations is often a moot point, because State efforts to monitor jail conditions are almost always very lax. Twelve States have no jail inspection programs of any type (Ford and Kerle 1981), and fewer than half have established clear enforcement mechanisms (Henderson et al. 1981). Furthermore, many of the States that do inspect local jails only have one or two persons assigned to this task (O'Neil 1978).

The failure of the States to develop and enforce a significant body of jail standards can be attributed to a widespread legislative reality: a written set of abstract statements indicative of good intentions is far less volatile than a State agency empowered to interfere with local policy. Moreover, since responsibility for most jails in the United States falls under the jurisdiction of the politically powerful county sheriff, even if State jail standards were more specific, implementation could still be effectively thwarted in many locations.

Officials interested in improving jail mental health services have thus frequently been unable to depend on the States for either guidance or supervision. And because no change in this situation appeared imminent, several professional organizations decided to promulgate operational standards of their own. The first to enter the field was the

American Public Health Association (APHA), which did so in response to its overall mandate to improve the quality of health care. The development of standards became a formal goal in 1972, and 4 years later the executive board approved the final draft submitted by a Jails and Prisons Task Force. Standards for Health Services in Correctional Institutions (American Public Health Association 1976) contained only six "principles" specifically related to mental health programming, but the efforts of APHA represented an important first step and served as a basis for the formulation of more comprehensive standards in the years that followed.

The origin of the involvement of the American Medical Association (AMA) with jail standards can also be traced to 1972, when the organization conducted a national survey of local correctional facilities to identify areas in which the delivery of inmate medical care needed improvement. In June 1975, AMA received a grant from the Law Enforcement Assistance Administration (LEAA) to investigate some of the more glaring deficiencies which the survey had documented. The project had three principal objectives: (1) to develop model health care delivery systems in jails at several pilot sites around the country, (2) to establish a clearinghouse for the dissemination of information and technical assistance, and (3) to prepare a series of jail health care standards that could be used for implementing a national accreditation program (Anno et al. 1981). In March 1979, AMA published the first draft of Standards for Health Services in Jails.

While still in the process of gathering information for use in drafting the standards, AMA sought the assistance of the American Association of Correctional Psychologists (AACP). It was subsequently agreed that Robert Levinson, then president of AACP and Director of Psychological Services for the Federal Bureau of Prisons, would be given a seat on AMA's Special Advisory Committee. Levinson felt that the final version of the AMA standards had lost much of the impact and creativity of earlier drafts and he therefore encouraged AACP to compile its own correctional standards. The final product, an article titled "Standards for Psychology Services in Adult Jails and Prisons," was released in March 1980.

In 1977, while AMA was still deliberating, ACA published a draft of Standards for Adult Local Detention Facilities. ACA was and continues to be the largest, most

influential organization of corrections professionals in the country, so it came as no surprise that ACA made guidelines available for the overall management of local jails. Like the standards proposed by DOJ, those of ACA address a number of administrative issues in addition to the narrower topic of inmate medical care.

In December 1980, the DOJ (1980a) issued a series of guidelines under the heading of Federal Standards for Prisons and Jails. These standards were reportedly written to help the Department maintain consistency in Federal correctional programs, and they constituted one part of a bigger project to develop a comprehensive Federal corrections strategy.

The interest in correctional standards that emerged during the 1970s cannot be attributed solely to concern about deinstitutionalization and its impact on mental health care in jails. In fact, there was much more concern about medical care generally than about mental health services in particular. The 1972 AMA survey confirmed the worst fears of knowledgeable observers and shocked many authorities who had no idea how poor medical care in jails really was. The survey found that 17 percent of all jails had no internal medical facilities at all and that another two-thirds had only a first-aid station. Just over half had a physician available on an on-call basis. At 31 percent of the jails, no physician was available to treat inmates (Steinwald 1973).

Another major factor in the emergence of these various standards was the fact that the courts were beginning to intervene on behalf of inmates who alleged cruel and unusual punishment. Judges had traditionally been reluctant to interfere with internal correctional policies on the grounds that jail superintendents had far more expertise in such matters. The judges had, therefore, adopted a hands-off approach for all but the worst cases. This policy began to change in the early 1960s when Black Muslim prisoners persuaded the courts that their constitutional right to religious freedom was being routinely violated. Successful litigation spread from the guarantees of religious freedom of the First Amendment to other areas, and it soon became clear that the denial of adequate medical care was implicitly forbidden by the Eighth Amendment (Winner 1981). Thus although jail officials would probably have been very concerned about the welfare of mentally ill prisoners in any case, the task of

developing standards to meet those concerns was given greater impetus by a number of unrelated factors.

In the remainder of this chapter, the actual content of the standards is examined to determine their recommendations, their differences, and the extent to which they represent a viable planning tool for jail administrators. The discussion focuses primarily on the standards proposed by AMA, ACA, and AACP. Although APHA was the first to develop specific health care guidelines for correctional institutions, that original work will not be referred to extensively, because it has not been revised or updated. Similarly, the DOJ standards will be mentioned only briefly inasmuch as the authors of those standards relied substantially on the standards promulgated by ACA.

The standards that will be presented here have been drawn from the most recent editions available. The AMA and ACA guidelines were revised in 1981. AACP has not yet revised the set of proposals it originally submitted in 1980. Each standard has been assigned a level of importance by the sponsoring organization. AMA and AACP use an "essential/important" dichotomy. ACA also describes certain standards as being either essential or important but has a third "mandatory" category for the standards that must be implemented for a facility to receive ACA accreditation.

One of the principal conceptual problems that had to be dealt with during the early development of all these standards concerned the level of care to be described. Some authorities argued that the standards should reflect minimally acceptable practices so that administrators would know what they had to do to satisfy basic legal and ethical obligations. Others insisted that the standards should reflect optimal goals, to serve as a guide for those who wished to develop truly superior services. The latter approach was ultimately rejected as being an unrealistic vehicle for reform. Because most officials lack the funding to implement an ideal set of procedures, it was argued that an ideal body of standards would have little to offer those who were seeking interim measures of improvement.

Administration

Many of the guidelines for mental health services are really generic statements for all health care in jails, rather than specific guidelines for mental health services. A major goal of all the standards is to promote an administrative framework that establishes clear lines of authority and ensures maximum cooperation between custodial and health care personnel. At a minimum, each job title filled at a jail should have a written job description so that there is no confusion regarding the exact role of each employee.

There is a unanimous belief that although medical/mental health professionals should adhere to all security regulations applicable to other facility staff members, they should also have clear autonomy to make and implement whatever decisions they believe are in the best interests of the inmates. APHA (1976) takes the position that this objective can best be accomplished when noncorrectional staff are used to provide evaluation and treatment services:

> All health care service units in correctional institutions should ultimately be accountable to a governmental agency whose primary responsibility is health care delivery rather than the administration of such institutions. It is felt that health agencies are more likely to possess the competence to evaluate and conduct health programs than those agencies whose expertise is in security and custody. Accountability to such an agency aids in promoting and maintaining the integrity and excellence of health services.

None of the other standards takes an explicit position on whether an external agency should be designated as the sole or primary provider of professional care for inmates. AACP does, however, recommend that the structure of the organization represent psychological services as a separate entity and that the unit budget be controlled by the chief psychologist.

The separation of professional and custodial responsibilities is a concept that underlies many of the recommendations found in the standards. AMA and AACP in particular stress that health care personnel should not be

called on to provide services for the sole purpose of facilitating management of inmates. Examples of the inappropriate use of professional resources include asking medical/mental health staff to provide special housing for homosexuals or for informers in the infirmary, to conduct body cavity searches for contraband, and to apply physical restraints to disruptive inmates who are not mentally ill. Similarly, talking to "troublemakers" is inappropriate when the inmates' actions stem from anger rather than a psychological disturbance. According to AACP, professional assistance should be offered only if staff action will directly benefit the inmate. Intervention that may be indirectly helpful to the prisoner is probably a management strategy and is less likely to be within the province of psychological services.

All the standards maintain that the **principle of confidentiality**, which exists in noninstitutional settings, should also be applied in local detention facilities. They unanimously indicate that health records should be maintained separately from the general confinement record and that all access to the records should be controlled by the chief treatment professional. Other recommendations on how this principle should be applied vary greatly in their specificity. The issue of implementation is crucial because many jail psychologists work for the sheriff and because an inmate's legal status could be seriously compromised if information obtained in a therapeutic relationship were to be eventually divulged to legal authorities.

ACA and AMA discuss confidentiality primarily in the context of health records. According to the ACA standard (1981, p. 78), the health authority should share with the facility administrator information regarding "an inmate's medical management, security and ability to participate in programs." AMA (1981, p. 42) does not specify any exceptions to the rule of confidentiality in the standard itself, but the ensuing discussion also refers to the desirability of sharing information relevant to "medical management and security." APHA (1976, p. 30), in applying somewhat more rigorous criteria, asserts that the only exceptions to the rule of full confidentiality should be the "normal legal and moral obligations to respond to a clear and present danger of grave injury to self or others and the single issue of escape." Satisfactory compliance includes having the therapist explain the guarantee of confidentiality to the client as well as the "precise delineation" of the foregoing limits. The therapist

should also periodically review the guarantee and its limits in order to stay aware of them. The official position of AACP (1980, p. 98) is noncommittal: "A written policy exists and is implemented which outlines the degree to which confidentiality of information can be assured." Subsequent comments in the discussion, however, closely parallel the recommendations of APHA. ACA and AMA neither implicitly nor explicitly indicate that inmates should be made aware of confidentiality limitations.

The decision to adopt a strict interpretation of confidentiality does not, of course, preclude a high degree of cooperation among correctional personnel, the facility administrator, medical staff, and related professionals. AMA and ACA recommend that the superintendent and chief health authority meet at least quarterly to discuss mutual concerns and the optimal utilization of resources. AACP also endorses this practice but suggests that monthly meetings be scheduled. ACA and AACP further suggest that the health authority or chief psychologist submit a quarterly report to the facility administrator. The report would include comments on such issues as the effectiveness of the health care system, a description of any health-related environmental factors needing improvement, changes effected since the last reporting period, and, if necessary, recommended corrective actions. AACP and APHA also want professional staff to participate in the preparation and implementation of facilitywide planning. These organizations note that it is important for mental health personnel to view themselves and be viewed by others in the facility as part of the institution's total operation. However, mental health professionals who participate in administrative decisionmaking processes, such as approving inmates for work release, should not also be expected to provide direct therapeutic services.

All the standards would foster day-to-day communication between correctional and medical/mental health staff in a similar manner. Specifically, written policy should require joint consultation before either group orders changes in the housing or programming assignments of inmates who have been diagnosed as having significant medical or psychiatric illnesses. They should also consult whenever such inmates are being considered for transfers or are about to be punished for disciplinary infractions. A good working relationship will ensure that medication does not endanger the safety of inmates who perform potentially hazardous

maintenance tasks and that the transportation staff receive proper instructions for transporting disturbed prisoners to other facilities.

Staffing and Professional Development

All the standards recommend that someone be specifically designated the "chief medical/mental health authority." This person would be responsible for making sure that needed care is arranged in a timely manner and that adequate supplies are routinely available. The person designated would also be expected to make plans for future service development and to supervise professional staff. AMA (1981, p. 2) would like to see this role filled by a "physician, health administrator or agency," whereas ACA (1981, p. 68) refers more generically to a "health authority." Both organizations suggest that this person oversee environmental conditions, delivery of medical and dental services, personal hygiene, and dietary/food services as well as mental health programming.

AACP (1980, p. 89) stands alone in insisting that a psychologist be named to administer psychological services: "While it may be argued that good managers can be effective regardless of their degree of knowledge of the area being managed, this standard rejects such a contention. Efficient management is predicated on both expertise concerning psychological services and management skills" (emphasis in the original). Consequently, AACP specifies that the person in charge of psychological services have a doctorate in a program that is "primarily psychological" as well as "appropriate training and experience." Although opinions differ as to the type of background that would be most useful in this position, the standards agree that the responsibility should not be assigned to an officer or correctional administrator.

The provision of timely care at many of the larger jails will require that the health authority or chief psychologist be assisted by other professional personnel. The standards provide mixed guidance, however, on staffing. AMA (1981:6) states only that there should be "adequate staff ... as determined by the health authority." According to ACA (1981, p. 70), the facility should "systematically determine its personnel requirements in all categories on an on-going basis to ensure inmate access to staff and the availability of support services." Only AACP offers what it considers to be

a desirable ratio of inmates to staff. If the average daily population is less than 10, a psychologist should be on call. Jails with an average daily population of 11 to 75 should have a psychologist at the facility for at least 8 hours a week. If there are between 76 and 125 prisoners, the psychologist should be at the facility at least 16 hours a week, and when the population exceeds 125, the jail reportedly needs a minimum of one full-time psychologist. AACP (1980, p. 95) has an additional expectation that the size of the psychological services staff will increase "as the level of special needs and/or program intensity differs from the average."

It is strongly suggested by all the standards that State licensing and other certification requirements be applied to health care personnel at the jail and that verification of each person's credentials be kept on file. In the past, professionals employed by Federal, State, and local governments have been exempted from statutes that establish minimal occupational qualifications, but this practice is clearly inconsistent with the stated goal of maximizing the quality of inmate care.

The use of inmates to provide health care services is virtually forbidden. All standards prohibit prisoners from giving direct patient care, scheduling health care appointments, determining the access of other inmates to health care, and handling medication. AACP would also ban inmates from being involved in administering psychological tests, scoring the tests, and filing psychological data.

The need for technical training is recognized and addressed at length by all the standards. It is recommended that professional staff receive two types of instruction: (1) orientation to the facility and an overview of how medical/mental health personnel function in a correctional setting and (2) continuing education. AACP states that the orientation should be given to new employees during their first month of employment, while ACA maintains that it should be completed before the employee is assigned to function independently in a particular job. Some form of continuing education is also needed so that staff members can keep their skills up-to-date and stay informed of significant developments in their field. A training plan should be prepared that is consistent with the requirements of relevant State licensing boards. Such a plan would outline both the amount and the frequency of the instruction needed

for each staff position. ACA is alone in specifying the number of hours that should be allotted for professional training: 40 hours of orientation, 40 hours during the first year of service, and 40 hours each year thereafter.

Making arrangements for basic and in-service training of correctional officers should also be a top priority for facility administrators. The standards suggest that officers be taught the signs and symptoms of mental illness, the actions to take when responding to medical/psychological emergencies, the way in which inmates should be referred to the mental health unit for services, and the procedures for transferring inmates to inpatient psychiatric facilities. ACA and AMA also recommend that officers be trained in the proper administration of medication. Although officer training would obviously encompass a number of topics unrelated to mental health, ACA proposes that officers receive a total of 40 hours of training each year. According to AACP, the chief psychologist should have the specific responsibility of seeing that all facility staff have an understanding of basic mental health care.

Identification and Management of Mentally Ill Inmates

All the standards rank intake screening as one of the most important services that a jail can offer. This assessment is usually described as a three-part process. First, the booking officer should review any papers or records accompanying the prisoner. The second step involves asking the inmate a series of questions about his or her mental health history. The questions should determine whether the person has ever attempted suicide, been admitted to a psychiatric hospital, or committed acts of sexual deviancy. The officer should also try to ascertain whether there is a pattern of violence or substance abuse and whether the inmate is currently taking any medication. Finally, the officer should record visual observations of the inmate's behavior. Of particular interest are signs of delusions, hallucinations, peculiar speech and posturing, disorganization, depression, memory deficits, and self-mutilation. In addition to developing standards for the intake process, AMA has prepared a model form specifically for screening incoming prisoners.

Although the implementation of a screening procedure is widely encouraged, it is designed only to identify disturbed inmates who respond affirmatively to questions about mental health problems or who manifest overt signs of mental

illness while being booked. It is thus possible that inmates with serious psychiatric problems will still go undetected. It is also possible that the stress of the jail environment or uncertainty about an upcoming trial will cause some prisoners to break down after they have been admitted. One strategy for identifying all inmates in need of services is to train correctional officers to recognize the symptoms of mental illness. Another strategy, which the standards unanimously recommend, is to grant inmates "unhindered access to medical/mental health personnel." Inmates should receive written notice at the time of admission of the procedures to be followed for requesting psychological services. AMA and ACA also recommend that a thorough health assessment be completed for each inmate within 14 days after arrival at the facility. The examination would be primarily medical in orientation, although the opportunity should be used to collect additional information for completing the psychiatric history.

Formal evaluations can be of an emergency or nonemergency nature. AMA and AACP recommend that assessments of inmates referred for comprehensive psychological evaluations on a nonemergency basis be completed within 14 days of referral. In cases of emergency, there is a consensus that the inmate should be held in a special area with constant supervision by trained staff while waiting to receive professional attention. According to AMA and ACA, no more than 12 hours should elapse before emergency care is rendered. AACP sets a deadline of 24 hours.

Once the evaluation has been completed, a decision must be made on whether the inmate should be referred for appropriate care. AACP (1980, p. 103) calls for the referral of any inmates "having mental problems." AMA and ACA propose a somewhat more limited policy. AMA (1981, p. 10) urges jails to refer prisoners "with acute psychiatric and other serious illnesses as defined by the health authority." ACA (1981, p. 73) recommends that a referral be made if the individual's "adaptation to the correctional environment is significantly impaired."

If an inmate requires psychiatric treatment beyond what can be provided at the jail, the standards agree that the person should be transferred to a facility where the needed services can be obtained. It is important that the facility administrator and responsible physician consult before the actual transfer is made. AMA notes in the

discussion of this standard that written operating procedures for routine transfers should include an assessment of the person's suitability for travel. The discussion also suggests that special care be taken to set aside any medication that will be needed en route and that special instructions be provided for the transportation staff when appropriate. In a separate standard, AACP specifies that during transfer an inmate should be restrained with the least restrictive means possible and be accompanied by a trained staff member.

Mental health officials may, of course, decide to keep the less seriously disturbed inmates at the jail. If so, the standards take the unanimous position that professional staff should have "adequate" space, equipment, supplies, and materials as determined by the health authority or, in the view of AACP, by the chief psychologist. In the discussion section following its standard on the special handling of patients with acute illnesses, AMA (1981, p. 10) also sets three "conditions" that should be met if psychiatric treatment is to be provided at the jail:

1. A safe, sanitary, and humane environment as required by sanitation, safety, and health codes of the jurisdiction;

2. Adequate staffing/security to inhibit suicide and assault (i.e., staff within sight and sound of all inmates); and,

3. Trained personnel available to provide treatment and close observation.

AMA is also the only organization that sets specific requirements for the operation of an infirmary or hospital.

AACP (1980, p. 108) states that it is "essential" for written, individualized treatment plans to be prepared for inmates requiring close medical/psychological supervision. The plan should include directions to nonmedical staff regarding their role in the "care, treatment and habilitation" of the inmate. AMA (1981, p. 30) also recommends that treatment plans be prepared but assigns the task a rating of "important" rather than "essential." ACA incorporates the development of treatment plans into a separate body of prison standards but does not refer to the topic in its standards for local detention facilities.

AACP apparently concluded that the use of medication falls outside its areas of expertise and thus remained silent on the issue. Medication is, however, discussed at length by AMA (1981, p. 38) and ACA (1981, p. 77). Both assign their highest rating of importance to the idea that psychotropic medication should be used only "when clinically indicated and as one facet of a program of therapy." They also agree that the prescribing physician should reevaluate each prescription prior to renewal and that stop-order time periods be required for all medications. Only AMA discourages the long-term use of minor tranquilizers and explicitly forbids the use of psychotropic medication for disciplinary purposes.

It is not clear what types of treatment should be available to medical/mental health professionals for the purpose of selecting the "other facets" of therapy that will accompany medication. The basic philosophy underlying all these standards is that the health care provided in institutions should be equivalent to the care available in the community. AMA and ACA, however, tend to be quite vague regarding the specific mental health treatment services that ought to be made available, and AACP does not give its list of proposed services the strength of an actual standard. APHA (1976, p. 31) recommends "varied modalities" and "eclectic breadth." At a minimum, satisfactory compliance with the APHA standard on direct treatment requires that the facility provide crisis intervention, brief and extended evaluation/assessment, group and individual short-term therapy, group and individual long-term therapy, therapy with family and significant other persons, counseling, medication, inpatient hospitalization for severely disturbed persons, and detoxification.

The standards concur that whatever type of treatment is to be used, the principle of informed consent as applied in the jurisdiction should also be applied to inmate care. AMA and ACA indicate that care can be rendered against an inmate's will only in accordance with State law, but AACP would also require that the decision to apply coercive treatment be preceded by interdisciplinary review if time permits. The use of physical restraints would be controlled by all standards through the implementation of written policies identifying the authorization needed and specifying when, where, for how long, and in what manner restraints may be applied. Formulation of the substantive content of these policies, however, is consistently left to the discretion

of facility officials. Only ACA categorically prohibits inmate participation in medical and pharmacological experimentation.

Finally, AMA and AACP stress the importance of continuing care from the time of admission to the date of discharge. As part of this general orientation, both organizations encourage arrangements for postrelease followup care in the community whenever circumstances warrant it.

The Use of Standards to Develop Jail Mental Health Services

Basically, this vast array of standards leaves the planners of mental health services with a whole set of prescriptions but no guidelines on how to combine them into a coherent program, how to mount the program, or how to finance the program. Standards for organizing such services were developed at a time when there was a great deal of confusion among jail administrators regarding how they ought to care for the mentally ill inmates in their custody. Basic issues had not yet been clearly formulated, much less resolved, and it was not even clear which services would be judicially mandated. Officials were forced to improvise as best they could. One indicator of the contribution that organizations such as AMA and ACA have made is the fact that Federal and State courts have come to rely on their standards as a measure of culpability in suits alleging inadequate psychiatric treatment. In seeking to define the minimal level of care acceptable to medical and mental health professionals, the authors of the standards have, in effect, established the constitutional touchstone against which jail services will be compared in court. Several judges have already ordered that local correctional facilities be brought into compliance with organizational standards in order to correct program deficiencies (Connors 1979; Wilson 1980).

Perhaps the single most important theme that emerges in the standards is the need for all health care services to be delivered in the context of a formal, structured program. Planning for mental health care, in particular, has traditionally been haphazard. More often than not, responsibility for mental health care has been an implied responsibility of the jail medical staff, and services were arranged only as needed. The standards stress that this approach is no longer acceptable. Individual administrators may apply a certain recommendation in a variety of ways to conform with local

tradition and circumstances, but all sources of assistance must be identified in advance of need so that care can be provided on a 24-hour basis. Moreover, once in place, policies and procedures must be reexamined at least annually and updated as appropriate. AACP (1980, p. 93) also calls for a "formal documented annual review" to be conducted by an outside agent to monitor conformity with the standards.

While the standards are helpful tools, a number of limitations must be recognized. To begin with, the standards do not always agree on the ways in which broad principles of care can best be implemented. This can be seen in the table II-1 (presented at the end of this chapter), which highlights some of the key differences in the proposed methods of organizing mental health staff and services. Another problem is that many of the standards are worded so broadly that they provide very little actual guidance. Some generalization is necessary to make the standards as widely applicable as possible, but the specific meaning of critical terms often remains unclear. For example, what constitutes an "adequate" amount of space and equipment for medical/mental health staff? What kind of "training" and "accountability" are appropriate for volunteers? Who should be allowed to authorize the use of involuntary restraints? The standards uniformly call for standard operating procedures to guide mental health staff in virtually all their activities, but the actual substance of these procedures is not always given sufficient attention.

Although some standards are quite specific, they can often be overly demanding as well. The organizations that have drafted standards for services in jails have also included some of the same recommendations in their standards for prisons. Several experts have questioned the wisdom of this decision. Of the 3,500 jails in the United States, approximately half have a designated capacity of fewer than 25 inmates, and another 25 percent have between 25 and 50 beds (Carter et al. 1975). Furthermore, research conducted by Flint (1978) indicates that many of the planners who set jail standards seldom take the time to visit a rural facility. It is thus possible that planners do not fully appreciate the challenges involved in operating small county jails. A glaring example is the "essential" ACA standard that correctional officers receive at least 40 hours of training annually. According to a 1982 national survey conducted by the National Sheriff's Association, 11 percent of all jails in the country do not have enough officers to provide 24-hour coverage

(Kerle and Ford 1982). And many of those that do consider themselves fortunate if they can arrange to excuse personnel from duty long enough to attend a single in-service lecture during the course of a year.

The authors of the standards respond to charges of unrealistic expectations by saying that even if a given provision seems burdensome, it is still a necessary element in the delivery of minimal health care services. Whether a facility is small or large, rich or poor, certain core services must be made available. AMA is also quick to point out that one jail in Indiana has won accreditation despite having an average daily population of only two inmates (Rowan 1977). The fact remains, however, that most jails are old, understaffed, and underfinanced. And although there are undoubtedly valid medical reasons for requiring that psychotropic medication be administered only as one facet of a program of therapy, many administrators simply cannot afford to provide additional treatment. The net result is that many jails will never be able to qualify for AMA accreditation, which as of July 1981 had been earned by only 96 facilities (3 percent).

Significant reform is elusive because of the chronic shortage of public funds and the indifference of many citizens to the plight of people who willfully break the law. Complicating the situation still further is the fact that jails tend to operate in a highly politicized atmosphere. Hiring criteria and planning priorities are likely to be heavily influenced by any number of considerations that are only marginally related to the professional operation of the facility. At least part of the problem, however, can be attributed to what is perhaps the single biggest limitation of jail standards: they focus on content to the virtual exclusion of the form that is needed to implement that content. Administrators are told what to do, but not how to do it. Standards simply are not a blueprint for the development of better services. Rather, they are statements of desirable goals which jail officials should try to meet as best they can.

In fairness, it should be noted that the standards are not really intended to provide detailed instructions for implementation. Their sole purpose is to identify those policies and practices that ought to be followed when planning the delivery of jail mental health services. To help administrators implement the policies, the AMA standards indicate that a series of monographs is available, but these

monographs tend to lack the kind of specific detail that would be needed by officials to introduce new services on their own. Technical assistance is available for those who are able to pay for it, but once again, jail authorities usually have very limited discretionary funds.

The major contribution of all jail mental health standards lies in the fact that they give planners of jail mental health programs a clear statement of objectives to guide their programming efforts. Many officials will still be left wondering, however, what they can or should be doing to obtain the recommended services. AMA (1981, p. iii) recognizes that "reliance on community resources for manpower and facilities is the only way that most facilities can provide special services such as detoxification and psychiatric care." Nevertheless, little attention has been paid thus far to the crucial linkages between correctional and mental health agencies. Chapter III suggests the utility of an interorganizational approach to specifying the structure of jail mental health programs and lays the groundwork for a subsequent analysis of how these programs can be planned and implemented.

Table II-1. Key differences in professional standards for the treatment of mentally ill offenders in a jail setting

	Standards of		
	American Medical Association	American Correctional Association	American Association of Correctional Psychologists
Professional staff			
a. Number	If health services are provided in the facility, adequate staff ... as determined by the health authority are provided for the performance of health care delivery. (105, Important)	The health authority systematically determines health care personnel requirements in order to provide inmate access to health care staff and services. (2-5268, Essential)	In jail settings, the following minimum staffing pattern applies: a. average daily population less than 10—psychologist on call; b. average daily population between 11 and 75—contract psychologist in the facility at least 8 hours a week; c. average daily population between 76 and 125—contract psychologist in the facility at least 16 hours a week; d. average daily population over 125—at least 1 full-time psychologist. (12, Essential)
b. Training	A written plan approved by the health authority provides for all health services personnel to participate in orientation and training appropriate to their health care delivery activities and outlines the frequency of continuing training for each staff position. (119, Essential)	Written policy and procedure provide that all new support employees who have regular or daily inmate contact receive 80 hours of orientation and training during their first year of employment. Forty of these hours are completed prior to being independently assigned to a particular job. They are given an additional 40 hours of training each subsequent year of employment. (2-5082, Essential)	A written plan, approved by the chief psychologist, is implemented ... and requires psychology staff to receive orientation training and regular continuing education appropriate to their activities. Documentation of these training experiences will be maintained. (13, Essential)

(continued)

Table II-1. Key differences in professional standards for the treatment of mentally ill offenders in a jail setting (continued)

	Standards of		
	American Medical Association	American Correctional Association	American Association of Correctional Psychologists
Services			
a. Screening and the threshold for referral	Written policy and defined procedures require post-admission screening and referral for care of patients with acute psychiatric and other serious illnesses as defined by the health authority. (110, Important)	Written policy and procedure require post admission screening and referral for care of mentally ill or retarded inmates whose adaptation to the correctional environment is significantly impaired. (2-5275, Essential)	Receiving screening is performed on all inmates upon admission to the facility before being placed in the general population or housing area..... Inmates identified as having mental problems are referred for a more comprehensive psychological evaluation. (73, Essential)
b. Treatment plans	Written policies and defined procedures guide the special medical program which exists for inmates requiring close medical supervision, including chronic and convalescent care. A written individualized treatment plan developed by a physician exists for these patients and includes directions to health care and other personnel regarding their roles in the care and supervision of these patients. (137, Important)	No standard.	A written treatment plan exists for all inmates requiring psychological services. This is developed by a psychologist in collaboration with other personnel and includes direction for non-psychological services personnel regarding their roles in the care and supervision of these prisoners.
c. Psychotropic medications	Psychotropic medications are prescribed only when clinically indicated (as one facet of a program of therapy) and are now allowed for disciplinary reasons.... Written policies and defined procedures require that the proper management of pharmaceuticals include discouragement of the long-term use of tranquilizers and other psychotropic drugs. (150, Essential)	Psychotropic medications are prescribed only when clinically indicated as one facet of a program of therapy. (2-5288, Mandatory)	No standard.

(continued)

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Table II-1. Key differences in professional standards for the treatment of mentally ill offenders in a jail setting (continued)

	Standards of		
	American Medical Association	American Correctional Association	American Association of Correctional Psychologists
d. Involuntary care	Obtaining informed consent may not be necessary in all cases. These exceptions to obtaining informed consent should be reviewed in light of each state's law as they vary considerably..... It is advisable that the physician document the medical record for all aspects of the patient's condition and the reasons for medical intervention..... In certain exceptional cases, a court order for treatment may be sought, just as it might in the free community. (Discussion with 155, Important)	Health care is rendered against an inmate's will only in accordance with the law.	Written policies and procedures exist and are implemented which outline the provision of involuntary treatment in accordance with state and federal laws and regulations applicable to the jurisdiction. These are approved by the chief psychologist and are in conformity with professional ethics and principles promulgated by the American Psychological Association and the policies established by headquarters in a multifacility system. The decision to such techniques shall be documented and based on (or, if time pressure precludes this, followed by), interdisciplinary review. Psychologists refuse to participate in practices inconsistent with legal, moral, and ethical standards regarding the treatment of clients. (15, Essential)
e. Referral at release	Written policy and defined procedures require continuity of care from admission to discharge from the facility, including referral to community care when indicated. (139, Important)	No standard.	There are written, implemented policies and procedures which require psychological services personnel to ensure that provisions are made for post-release follow-up care when appropriate. (39, Important)

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CHAPTER III

VARIETIES OF JAIL MENTAL HEALTH PROGRAMS

One of the goals of our research was to compile descriptive profiles of the range and mix of mental health services available for jail inmates at each of our study sites. This chapter provides an overview of our findings in this regard with special attention to the variety, mix, and distinctive service delivery approaches we encountered at the time of our initial fieldwork. The information presented here will serve as a detailed overview of our sample sites and background for the assessments of program effectiveness, program development, and staff conflict that will be considered in subsequent chapters.

In our depictions of these various approaches to jail mental health services we have deliberately avoided use of the term "model programs." As noted in chapter I, models often tend to be somewhat idealized types that are difficult to fit into less-than-perfect, real-world systems of care (Bachrach 1980). Furthermore, a major finding that emerged from our work, which is detailed in chapter IV, is that there is no one best way to arrange jail mental health services. "Model programs," on the other hand, seems to imply that there is one best way, or perhaps a few best ways. Accordingly, in this chapter we discuss the four main approaches toward structuring mental health services that were observed across the 43 jails studied, and highlight the content of these programs. Chapter IV focuses on the organizational arrangements for these services, examining how jails relate to the range of mental health agencies that do, or could, provide services to jail inmates.

Criteria for Jail Mental Health Services

One of the initial problems encountered in our study was the absence of clear definitions and criteria as to what constitutes "jail mental health services." Although most observers would argue that some type of mental health screening or case identification is a minimal service element in a jail setting (e.g., Newman and Price 1977b), we could find little consensus in the available literature about the range of other service components that should be included. Accordingly, before conducting our initial site visits, we developed a broad definition of jail mental health

services on the basis of available reports and the standards promulgated by professional associations as presented in the preceding chapter. Nine possible service components were included in this definition: (1) intake screening at booking, (2) psychological evaluation following initial screening, (3) assessments of competency to stand trial, (4) use of psychotropic medications, (5) substance-abuse counseling, (6) psychological therapy, (7) inpatient care, (8) external hospitalization, and (9) case management or linkage of inmates with community mental health agencies following release. Although competency evaluations are a court-related assessment, we included them as a mental health service component because psychiatric services for jail inmates, both overtly and covertly, are sometimes arranged as part of the competency examination process (Geller and Lister 1978). All educational, legal, religious, social service, or other inmate activity programs not explicitly directed at the assessment or treatment of identifiable mental disorders or substance-abuse problems were excluded from consideration.

Intake screening is "a system of structured inquiry and observation designed to prevent newly arrived inmates who pose a health or safety threat to themselves or others from being admitted to the facility's general population and to get them rapidly admitted to medical care" (American Medical Association 1981, p. 23). A jail in our study was considered to have a screening process if (1) new inmates were routinely asked questions pertaining to their mental health (past suicide attempts, prior psychiatric hospitalizations, etc.); (2) the questions were printed on a standard form so that the booking officer would not have to rely on memory to remember specific questions or would not forget to make the designated inquiries altogether; and (3) the screening form was completed during intake.

Psychological evaluations were defined as question-specific assessments in which inmates receive a clinical interview focusing on a particular characteristic or set of circumstances that may be affecting their behavior. A jail in our study was considered to have an evaluation service if mental health professionals, on an as-needed basis, assessed inmates suspected of being mentally ill for reasons unrelated to competency, pre-sentence investigations, or other court-related functions. The jail had to initiate the evaluation as part of its own service program; the need for evaluation was usually identified through intake screening.

Competency evaluations are court-mandated assessments to determine whether defendants understand the circumstances surrounding their legal predicament and are able to cooperate with an attorney in their own defense. Jail officials cannot initiate such an evaluation, but the process occasionally occurs as the most effective way to get an inmate out of the jail and into a mental health facility. Jails in our study that held pretrial inmates who were given competency examinations either at the facility or in a mental health setting, such as a court clinic or State hospital, were recorded as having this service.

Psychotropic medication includes the antipsychotics or major tranquilizers such as Thorazine or Mellaril; antianxiety medications, such as Valium, that induce sedation; antidepressants, encompassing both barbiturates and amphetamines; and mood-stabilizing drugs, such as lithium, that are used for patients experiencing acute manic states. Study jails that used prescribed medications to stabilize disturbed inmates were considered to be offering this service regardless of whether the medicine was distributed by correctional officers or professional staff.

For a jail in our study to be viewed as providing **substance-abuse counseling** for inmates, the therapy had to have a clear psychological orientation and be offered for the purpose of helping the clients overcome their drug or alcohol problem. The counseling also had to be available to all inmates in need of it or to an appropriate subgroup as determined by jail or mental health officials. If the counseling was not done at the jail, correctional officials had to provide the necessary transportation. It thus did not suffice to give inmates on work release the option of obtaining outside counseling on their own. No minimum qualifications were established for the counselors in order for the site to be coded as having this service.

Psychological therapy was defined as consisting of a clinical interaction between an inmate and a mental health professional having at least a master's degree, which was oriented toward the goal of helping the client make some improvement in behavior. Although no restrictions were placed on the form (individual or group) or style (Freudian or Rogerian), the therapy had to be scheduled in a way that permitted more than just a superficial exchange of comments. It would not suffice for a psychologist to seek out a particular inmate on an irregular basis to "see how things

are going." Therapy would typically, although not necessarily, be given in the context of crisis intervention.

Inpatient care is a service provided for inmates whose illnesses are so acute that they can no longer be safely managed in a traditional correctional setting. The service is provided within the jail in an infirmary used in whole or in part to treat the mentally ill. A jail in our study was considered to be providing this service internally if infirmary beds were routinely used or reserved for disturbed inmates. The American Medical Association's criteria for an infirmary had to be met in order for a jail to be given credit for offering internal inpatient care:

> An infirmary is an area established within the correctional facility in which organized bed care facilities and services are maintained and operated to accommodate two or more inmates for a period of 24 hours or more and which is operated for the expressed or implied purpose of providing skilled nursing care for persons who are not in need of hospitalization.

External hospitalization may occasionally have to be arranged for inmates with serious long-term psychiatric needs or acute short-term needs that cannot be met within the jail. A jail was given credit for providing this service if seriously disturbed inmates were transferred to a local hospital, a State hospital forensic unit, or, in the case of nonviolent and low-risk inmates, to a civil unit within a State hospital.

Case management is a process in which inmates who need mental health care at the time of release are linked with appropriate community agencies capable of providing ongoing treatment. A jail in our study was seen as providing a case management service if (1) appointments were made with mental health agencies for all mentally ill inmates or for a specific subgroup such as those receiving psychotropic medication and (2) referrals were made for inmates with a variety of mental health problems. It did not suffice to give inmates the names and addresses of possible service providers or to make appointments only for those with substance-abuse problems.

These eight services constitute the core elements of mental health programming in local jails. Some jails,

however, may admittedly offer additional types of care or manage disturbed inmates in ways that are not readily captured within the range of services just listed. Larger facilities, for example, may have the capability to segregate all new inmates for a period of 48 to 72 hours so that correctional officers will be better able to identify mentally ill offenders before they are placed in the general population. Other jails may have a padded cell or special observation unit for inmates whose behavior seems particularly erratic.

Distribution of Service Components

As shown in table III-1, the services provided by jails vary considerably. Every jail offered some type of psychotropic medication program and all had some procedures to transfer inmates to external inpatient hospital settings. In fact, the waiting lists at many State hospitals were so long that for many jails inpatient hospitalization was an option on paper only. Moreover, all except one jail were found to have some arrangement for obtaining a special mental health evaluation of inmates after the initial screening had indicated potential mental health problems. In 40 of the 43 jails, competency examinations were available. The remaining three jails held only inmates who had been convicted, so the issue of competency was not relevant.

Less common program components were mental health screening at the time of admission (70 percent) and drug or alcohol counseling (60 percent). The least common services were any type of therapy beyond medications (30 percent) and case management at time of release (16 percent), although what staff termed case management was as limited, in most cases, as giving the inmate the address and telephone number of the local Community Mental Health Center.

In general, jails tended to equate identification and treatment with psychotropic medications. This situation is consistent with a crisis stabilization orientation associated with acute problems of persons in fast-turnaround facilities, like jails. Longer-term treatment and careful transfer of the inmate to community services at release were uncommon. As one jail administrator observed in regard to case management, "Correctional Officers don't care about what happens out on the street. Once the guy leaves, he's not their problem. He becomes a problem for the law enforcement agencies." At the same jail, another administrator noted, "If case management works well, the COs don't see

Table III-1. Service components of jail mental health programs (N = 43)

Type of service	Number of jails providing	Percentage of jails providing
Mental health screening	30	70
Evaluation	42	98
Internal	13	30
External	29	68
Psychotropic medication	43	100
Competency examinations	40	93
Drug/alcohol treatment	26	60
Therapy/counseling	13	30
In-patient care		
Internal and external	9	21
External only	34	79
Case management at release		
Substance abuse	16	37
General mental health	7	16

the results. Therefore, they don't appreciate the impact of those mental health services." Overall, then, the jails that were studied emphasized services that focused on the behavioral management of the inmate within the jail and not on longer-term mental health treatment concerns as they might benefit the inmate during incarceration or upon return to the community.

It is relatively easy to determine how many jails offered each type of mental health service, but it is much more difficult to summarize the various configurations of these individual components. Following our site visits, we carefully read, abstracted, and analyzed all field notes and interviews to categorize the approaches toward mental health services of the 43 jails we visited. The taxonomy that emerged from our review appeared to be a useful way of organizing the major types of programs we had seen. These categories and some examples of each are presented in the next section to provide a basis for understanding the interorganizational structure of these programs that is presented in chapter IV, and to help the reader better evaluate the

principles for program development that are discussed in chapter VII.

Major Approaches to Jail Mental Health Programs

From our site visits, four basic types of arrangements for mentally ill inmates seem to exist: (1) ad hoc in which virtually no services are offered except on an emergency basis; (2) **identification** in which correctional officials seek only to identify inmates who are disturbed; (3) **identification and treatment** in which the mentally ill are both identified and treated; and (4) **comprehensive** in which identification, treatment, and referral services are all available. Other combinations of program options can be derived conceptually, but these service types summarize the wide range of programs that were studied here.

Each approach has a distinct set of goals, program characteristics, and underlying philosophy as to what a jail can and should do for the mentally ill. But the assumptions, goals, and program philosophy associated with each type proved to be less clearly defined in the minds of key actors than our discussion of their underpinnings suggests. Policymakers at the sites sometimes followed a formal planning process in which a task force considered the various ramifications of modifying the existing service structure, but more often, the mental health programs seemed to evolve somewhat haphazardly. For example, one jail hired a nurse who took the initiative to implement a new screening program without any specific direction or encouragement from the sheriff to do so. The head nurse at another jail happened to meet a former schoolmate who had started working at the local mental health center and the two agreed over lunch to join forces in developing a substance-abuse program for sentenced inmates. At several sites, annual changes in the level of funding caused sudden, perhaps unexpected changes in the services. Thus, although jail administrators may never formally decide to "identify" the mentally ill as distinct from both "identifying" and "treating" them, the ongoing programs nevertheless did seem to sort themselves into four distinct groups.

Ad Hoc Approach

Jail officials who provide ad hoc psychological services make arrangements for mental health care on a case-by-case, as-needed basis. No systematic attempt is made to

identify mentally ill prisoners, and little if any treatment other than medication is routinely made available while the inmates are incarcerated. Special care is offered only in emergencies, typically involving a suicide attempt or psychotic episode. Disturbed prisoners about to be released are seldom if ever referred to agencies that can provide appropriate care in the community.

The mental health goals of an ad hoc jail tend to be modest: (1) to stabilize severely disturbed prisoners and (2) to transfer those inmates who can no longer be safely managed to an inpatient psychiatric facility. Correctional staff make a bona fide effort to react promptly in crises, but they do not see their role as one of anticipating less critical inmate needs and intervening as soon as a potentially serious problem is detected. They acknowledge no responsibility for mentally ill inmates other than to ensure their basic safety while in custody. The jail strives to meet but not exceed its strict legal obligations.

When a person is admitted to the jail, no effort is made to determine if the person will be able to make a satisfactory adjustment to the correctional environment. Routine intake procedures vary only when the inmate is totally disoriented as to time and place or has been held at the jail before and the booking officer knows that the person has a history of mental illness. Even then, clinical services will seldom be arranged unless the inmate poses a serious threat to himself or herself or to others. A common response is to make a note in the log indicating that the person should be watched a bit more closely than normal.

If an inmate in the general population begins to exhibit signs of abnormal behavior, the initial staff reaction typically consists of "wait and see." Any number of management techniques may be employed to keep potential disruptions to a minimum, but only when the behavior can no longer be ignored will professional assistance be sought. Medical personnel, often a licensed practical nurse (LPN) or paramedic, are usually asked to examine the prisoner to determine whether a formal evaluation should be scheduled, and if so, whether it should be done on an emergency or nonemergency basis. If it is ultimately decided that inpatient care is required, the inmate will be transferred to an appropriate facility. Otherwise, the person will be stabilized and given the minimum ongoing treatment necessary to maintain the stabilized condition.

Jails with an ad hoc mental health program offer few services of any kind. GED (high school equivalency) instruction and job counseling may be available to inmates who are interested, but such activities are the exception rather than the rule. Alcoholics Anonymous (AA) may also be allowed to conduct weekly meetings if a suitable room can be reserved for this purpose. Substance-abuse counseling is technically a form of treatment, but it is seldom used in a way to help individual inmates overcome destructive drinking habits. Any prisoner who wishes to attend an AA meeting is generally given permission with no preliminary screening or prior determination of need.

Rural southern jail. A good example of a jail that provides mental health services on an ad hoc basis is located in a southern county of approximately 30,000 residents. The facility has a rated capacity of 17 beds but it frequently olds 25 to 30 prisoners because severe overcrowding in the State correctional system causes lengthy delays in scheduling the transfer of sentenced felons. The jail is operated by a sheriff who has been in office for 9 years.

The sheriff's jail staff consists of four deputies and two transport officers, none of whom has had any formal training. The sheriff does not have enough personnel to provide 24-hour coverage at the jail, so officers assigned to the county's road patrol check the inmates periodically during the evening and early morning hours.

The political atmosphere in the surrounding community is very conservative. There is a widespread consensus that because inmates have willfully committed a crime, they should not expect to receive any nonemergency services while incarcerated. As a result, no activities are scheduled at the jail except for a weekly 30-minute visit by a minister. The county did construct a new jail in 1969 to provide better security and office space for the sheriff, but the cells in which the inmates are actually housed were taken from the old jail, which was built in 1902.

The sheriff sees no need to contract with a physician for services, preferring instead to rely on one of the jail deputies who is an emergency medical technician. This deputy has the responsibility of arranging care for inmates who are acutely disturbed. A prisoner who needs an immediate psychological evaluation is brought to the emergency room of the county's only hospital. Nonemergency

evaluations are scheduled at a satellite unit of a regional mental health center. Jail officials estimate that fewer than 1 percent of all inmates ever require an evaluation. According to the psychologist at the clinic, however, the jail waits until the last possible minute to make an appointment and only patients in an acute state are ever brought to his attention. Even then, he generally concludes, the inmates are in much worse condition than the jailers seem willing to believe. The inmates are eventually billed for the cost of this evaluation, but because most do not pay, the county is considering a proposal to impose a $1 charge in advance so that at least some of the malingerers can be eliminated.

Inmates who require inpatient psychiatric treatment are sent to one of two State hospitals. Use of one facility is limited because it does not have a locked ward. Admitting doctors are reluctant to accept inmates who may pose a threat to others and the jail is reluctant to send inmates there in any event because of the lack of security. It is not against the law in this State for a prisoner to escape from a mental institution, so escapes have been frequent. The second hospital available to the jail does have a secure unit. Several other local correctional facilities are also located within the hospital's area, however, and because bed space is very limited, inmates often have to wait 8 months for admission. Jail officials concede that they do not provide adequate care for psychotic inmates awaiting transfer. According to the sheriff, the only reason that the jail has not been placed under a court order is that "no one has bothered to file suit."

Urban midwest jail. The second example of ad hoc jail services is located in a midwestern county with 150,000 inhabitants. This facility has an average daily population of 128, which is just within the designated capacity. Operation of the facility is officially the responsibility of the county sheriff.

In 1978, this jail entered into a far-reaching consent decree that affected the quality of food, availability of law books, opportunities to exercise, and visiting regulations, among other things. Under the terms of the agreement, the jail was also expected to provide nonemergency psychiatric care within 48 hours to inmates who requested it. Despite the apparent need for major changes in jail operations, the county Board of Supervisors had recently rejected the sheriff's requests for additional funds. Included in that

request was a proposal to hire an outside consultant to assess inmates' mental health needs. At the time of the site visit, jail officials were preparing to go to court to answer charges that they had violated the decree.

The jail employs 25 sworn deputies, 7 nonsworn correctional officers, and 8 support staff. None of the custodial staff has received any formal training. The jail also employs a nurse 1 day a week. The policy manual indicates that the nurse is expected to examine all inmates who have been admitted since her last visit, but other more pressing responsibilities often preclude this practice.

The jail administrator does not believe that the facility needs an extensive mental health program. Recent changes in State law allow police officers who arrest someone suspected of being mentally ill to bring that person directly to a mental health facility. This procedure is reportedly successful in preventing those who are obviously disturbed from being brought to the jail. The administrator feels that fewer than 1 percent of all inmates ever need a psychological evaluation in any case. In those rare instances when the need does arise, the shift supervisor can make an appointment at the county mental health center. A private psychiatrist is on call for the four or five emergencies that might occur during the course of a year. Inmates who must be given a competency examination prior to trial are taken to a State hospital.

The jail claims to have no difficulty in getting an inmate requiring inpatient psychiatric care admitted to an appropriate facility. The local mental health center has an inpatient unit used to stabilize nonviolent inmates, and the more aggressive prisoners can be placed in a State hospital forensic unit. Jail officials doubt that inmates would be willing to participate in therapy sessions at the jail even if such counseling were available because the prisoners are afraid of being labeled "nuts" by their peers.

The only nonessential service that the inmates receive is provided by Alcoholics Anonymous. Jailers insist that most inmates attend AA meetings only to get out of their cells, but the program is permitted to continue in deference to the wishes of an employee of the mental health center who does substance abuse evaluations of pretrial inmates for area courts. As proof that his approach to mental health is working, the chief administrator of the jail points with pride

to the fact that the facility has not had a successful suicide attempt in 25 years.

Identification Approach

The principal characteristic of jails with an identification approach is the attempt by correctional authorities to determine which inmates are mentally ill. Little treatment other than medication and emergency care is provided, but extra attention is given to any prisoner who appears to be disturbed and who may need such care in the future.

Mental health programming at jails oriented toward the identification of mentally ill persons emphasizes four goals: (1) identifying inmates who have serious psychological problems; (2) monitoring the condition of inmates whose behavior suggests they are somewhat unstable; (3) stabilizing prisoners who are acutely disturbed; and (4) transferring inmates who require inpatient care to a psychiatric facility. The goals are quite similar to those found in the ad hoc jails. Authorities in both want to protect the lives of mentally ill inmates and the lives of the people with whom the mentally ill come in contact, but the strategies used to accomplish these goals by both approaches do not include treatment in nonemergency situations. The identification model can be distinguished primarily by the proactive efforts of jail staff to determine which inmates are mentally ill in advance of a crisis. Information gathered during the identification process is intended more to help officials better manage the jail than to serve as a basis for correcting any psychological imbalance that happens to be found.

Identification services typically include some form of screening at intake. By gathering information on mental stability before the inmate is assigned to the general population, it is hoped that jail staff will be better able to decide whether the inmate should be placed in isolation from the outset or assigned to a regular cell with greater than normal supervision. Officials at the ad hoc jails expect their staff to make similar judgments without such procedures or special training.

Urban southeastern jail. One jail in the sample, which has a mental health program geared toward the identification of disturbed inmates, is situated in the third largest county (300,000 people) of a southeastern State. This facility officially has the capacity to house 129 inmates, but the

daily population is usually closer to 140. Administration of the jail falls under the jurisdiction of a county sheriff. The sheriff, in turn, has appointed a person with a master's degree in public administration to serve as the jail's chief of operations. The only other noncustodial staff members are two LPNs.

When the jail was built in 1971, facility planners expected that it would only be used to incarcerate prisoners who would be in custody for a few weeks. There were few delays at that time in scheduling court appearances, and the State department of correction promptly assumed custody of inmates receiving sentences of more than 30 days. It did not appear to be either necessary or logical to allot space for inmate programming of any type. Initial perceptions were not valid over the long run, however. In the years that followed, more and more offenders were incarcerated, and judges were no longer able to schedule hearings as quickly as they did when the jail was first designed. The average length of stay is now nearly 4 months. Jail officials literally do not have any room to set aside specifically for the delivery of mental health services, despite the current need.

Booking officers screen new prisoners for signs of mental illness and then send them to the nursing station for a physical examination. All officers are required to take a 40-hour training program that includes instruction in the nature of behavioral disorders and in the recognition of psychological disturbance. The nurses and the chief of operations also attend periodic mental health training seminars whenever possible. Line staff are not sent to these workshops because of the need to maintain adequate coverage at the jail, but they are kept informed of key points made during the various lectures via informal conversations at lunch or in the cell block. The early identification of disturbed inmates is given a particularly high priority at this jail because of its location just 3 miles from a major State hospital. It is estimated that 30 percent of all prisoners brought to the jail have been previously admitted to the hospital and that 60 percent have mental health-related problems.

Inasmuch as 95 percent of the inmates are awaiting trial, nearly all evaluations are handled as part of the competency process. When an inmate begins to behave in an aberrant manner, the jail notifies the inmate's attorney in the hope that a court order will be obtained to have the

prisoner examined. In 1980, a total of 64 inmates were evaluated in this manner. A private psychiatrist can be asked to come to the jail to evaluate sentenced prisoners, but this option is seldom exercised except in emergencies.

Just before the site visit, the chief of operations sought approval to hire a general resource person to oversee mental health service delivery and a social worker to act as a liaison with county mental health agencies. About 75 percent of all persons whom jail officials wish to have admitted to hospitals are hospitalized, but the remaining 25 percent receive virtually no care at all. The sheriff nevertheless refused to ask the county legislature to authorize the hiring of the new staff because the county was facing a $15 million reduction in Federal funding. The county manager concedes that the quality of psychological care at the jail is "poor," but points out that the jail is still basically a short-term facility and that inmates who are truly interested in receiving treatment can obtain it at the mental health center when they are released. The director of the mental health center, meanwhile, views forensic services at the jail as a "Johnny come lately" and rejects the suggestion that the jail should be part of the center's responsibilities. He notes that service delivery at the jail would be difficult in any case because the facilities are so noisy and cramped. What the jail needs most, in his opinion, is a mechanism for alleviating acute psychological distress and someone to make referrals at release so that clients can better take advantage of area mental health resources.

Urban midwest jail. Another example of a jail where officials have implemented an identification process can be found in the Midwest. The urban county that operates the jail has 309,000 residents. The sheriff has appointed a former chief of police with 30 years of law enforcement experience to run the jail.

The jail was built in 1973 to house 168 inmates. By 1981, the average daily population had reached 215, all but 15 of whom were awaiting trial. The county has responded to the overcrowding situation by forming a task force to monitor conditions at the jail and to develop strategies for keeping the population within manageable levels. The task force's principal accomplishment thus far has been to win approval for the construction of a new 80-bed work-release center. Although the county sends more people to prison on a per capita basis than any other county in the State, the

public is "very unwilling" to spend money for jail services. Because the State has no standards regulating the management of local correctional institutions, there seems to be little reason to fund jail services beyond the minimal level needed for the safe operation of the facility.

In many ways this jail is similar to the previously described urban southeastern jail. Both are medium-size facilities, are overcrowded, hold mostly pretrial inmates, and have very limited public support to develop inmate services. Unlike the chief of operations at the first site, however, the jail director in this county is adamantly opposed to the presence of any full-time mental health staff at the jail. His objections are twofold. First, he is convinced that the jail is not an appropriate place for the mentally ill to be held--"never has been, never will be." In keeping with that philosophy, the director refuses to use the jail budget to pay for any mental health care. Every organization that provides psychological services for inmates does so at its own expense or is paid by a third party.

The director's second objection to treating mentally ill prisoners at the jail stems from a fear that if he hired a psychologist, it would not be long before inmates began to take advantage of the person thus employed. "Pretty soon, everyone would need mental health services. The situation would mushroom out of control." The only treatment the director does allow at the jail, other than psychotropic medication, is drug and alcohol counseling. Alcoholics Anonymous (AA) conducts a meeting every Friday night and the public health department has assigned an outreach counselor to work with a group of eight inmates for a total of 2 hours a week. The substance abuse unit at the mental health center is also willing to send staff members to the jail but does not do so because the jail director is unwilling to help defray the unit's costs.

New inmates are screened by booking officers who have had 40 hours of basic training and who attend in-service seminars sponsored by community mental health agencies. Floor deputies are also required to receive this training so they can recognize inmates who exhibit symptoms of mental illness after intake. Emergency medical technicians supplement the initial screening by conducting a brief medical examination to check the inmate's mental status. A prisoner facing serious felony charges will initially be placed in a special observation cell as a precaution against possible

suicide attempts. An officer will then be assigned to monitor the inmate every 15 minutes and note observations in a special log.

Evaluations had been conducted by an on-call psychiatrist who was contacted whenever an inmate seemed to be in "desperate need." The practice was changed 10 months before the site visit when an inmate later diagnosed as psychotic nearly succeeded in killing himself. Jail officials realized they would have been liable for damages if the prisoner had died and have since called the crisis unit of the mental health center whenever it appears that an inmate has a serious mental illness. In the first 10 months of operation, the crisis unit has conducted 24 evaluations at the jail. However, inasmuch as the jail will not pay for the evaluations, a shift supervisor must first request that the prisoner's attorney obtain a court order to have the inmate examined. The mental health center can then bill the court for any costs that are incurred. Jail officials like this arrangement because the jail receives the service free and because the liability for a faulty diagnosis is transferred to another agency.

Inmates who need inpatient care are sent to the State's single forensic unit. Meeting the legal admission criteria is a source of considerable frustration for correctional officials. An inmate "must attempt to commit suicide about five times before the jail can get a court order for a 30-day evaluation. Sometimes it's a real fight, especially if the charges are minor." Once an inmate does cross the designated threshold, however, State law requires that the hospital accept the patient immediately. Since space is very limited, nondangerous inmates are usually assigned to unlocked wards. Equally troublesome, or perhaps even more so, from the jail's perspective, is the fact that prisoners are sent back to the jail as soon as they are stabilized. Inmates frequently return after just a few days. Overall, this jail is concerned with identifying all possible serious problems, primarily because of liability issues, and then providing treatment only as needed and in limited amounts.

Identification and Treatment Approach

Jails with an identification and treatment program approach have identification services to help officers determine which inmates are mentally ill as well as regular treatment services to help stabilize those who are in need of

professional care. No arrangements are made, however, for the continuation of that treatment once the inmate is released.

Although medication and substance abuse counseling are frequently integral parts of an inmate's overall treatment plan, they were not sufficient to warrant our designation of a treatment component per se. Other treatment services such as individual therapy and onsite hospitalization must have been available in order for a jail to be regarded as having a regular, ongoing treatment in nonemergency situations.

Identification and treatment approaches generally seek to accomplish five principal goals: (1) to identify any inmates having serious or potentially serious mental health problems; (2) to monitor the condition of disturbed inmates; (3) to stabilize disturbed inmates in crisis situations; (4) to provide professional mental health care for disturbed inmates when it is realistic to do so; and (5) to transfer inmates to a psychiatric facility when inpatient care beyond that available at the jail is required. The treatment of mental illness can be quite far-reaching. The Philadelphia city jail (Philadelphia Prison), for example, has a fully accredited psychiatric hospital. Treatment goals are typically immediate in nature, that is, to help the individual adapt to the conditions of confinement or to persuade the inmate that suicide is not the answer to problems.

When an inmate is admitted to a jail with identification and treatment services, the identification process usually includes an initial screening and some form of classification. Jail officials may not be able to treat all the inmates who are found to need nonemergency professional care, but at least a designated subgroup of these individuals will be routinely deemed eligible to receive those services that are available. The provision of treatment does not, of course, preclude the simultaneous use of one or more management techniques.

Urban western jail. A large western jail using the identification and treatment approach is located in a county covering approximately 8,000 square miles. The county has 400,000 permanent residents, but the population more than doubles during certain parts of the year as a result of a heavy influx of tourists.

The jail was built in 1960. Although it is still in fairly good condition, chronic overcrowding, lack of services, and poor administration led to a class action lawsuit in 1977. An expert witness described it as the second worst that he had ever seen in the United States. In 1979, the sheriff appointed a new administrator and signed a consent decree with 243 items addressing virtually every aspect of jail operations. The average daily population has since been reduced from 600 inmates to just over 250. The assistant director in charge of program planning noted that the limited availability of space was still a "great constraint" in his efforts to deliver high-quality mental health services. A new jail is currently under construction, however, which should enable him to develop new program options.

The decree has had a major impact on both the quality and the extent of the jail's mental health services. One of the new administrator's first acts was to hire a private corporation to provide all health services. The contract called for the corporation to recruit additional medical/mental health staff members to work at the jail, to assume responsibility for the day-to-day management of service delivery, and to bring the facility into compliance with those parts of the decree that concerned inmates' health care. In February 1981, the jail was accredited by the American Medical Association.

Trained booking officers screen new prisoners for signs of mental illness during intake; and all inmates receive a brief medical examination within 5 hours of admission. Those who need further evaluation are referred to the staff psychologist. If an emergency should arise when the psychologist is not available, shift supervisors notify the crisis unit of the community mental health center, which has a psychiatrist on call 24 hours a day.

According to the terms of the consent decree, suicidal inmates, mentally ill inmates, and any other prisoner whose adaptation to the general environment is "significantly impaired" must be referred for appropriate care. The decree further stipulates that an individual treatment plan be developed for these inmates by a physician or psychiatric professional and that a special classification process provide for their separate management and housing. Inmates who are ultimately determined to be medium- or high-security risks are to be observed by a correctional officer at least every 30 minutes on an irregular schedule.

Outpatient treatment is provided in part by volunteers from AA, who visit the jail once a week. The jail also has 13 nurses who distribute medication and look after other inmate needs. The program administrator of health services estimates that nearly a third of all inmates received psychotropic medication during 1980. She hopes eventually to replace much of the medicine with behavioral therapy. The therapy currently available tends to be quite informal, but the consent decree does call for at least one staff member to be available for counseling inmates at all times.

Prisoners who need inpatient psychiatric care are frequently sent to the jail infirmary. Although none of the 25 beds are routinely reserved for the mentally ill, usually at least two or three inmates are there for psychiatric reasons at any given time. Inmates can also be sent to a separate locked ward within a local hospital or to a State forensic unit. However, inadequate security has been a problem at the hospital in the past, and the forensic unit is 450 miles away. Jail officials use the forensic unit primarily for inmates' competency examinations.

The changes introduced at this jail over the past few years have reportedly improved the morale and attitude of both inmates and officers. The innovations have been expensive to implement, but officials indicate that taxpayers do appear willing to assume the costs of the new services. Details of the lawsuit and its aftermath were extensively reported in the local press, which ultimately raised the level of public concern for the quality of jail operations generally.

Urban northeastern jail. A second jail where officials identify and treat mentally ill inmates is in a northeastern county of just over 500,000 people. It is run by a county prison board consisting of three county commissioners, the sheriff, the district attorney, a judge, and the county comptroller.

The jail was built in 1884 and is now in very poor condition. According to ACA standards, each of the jail's 43 cells is only large enough to accommodate two inmates. The jail's population seldom falls below 170, however, so correctional staff have been forced to double the recommended occcupancy. Plans for a new facility have been stalled by community disagreement as to where the jail should be located.

According to a recent article in a national publication, the county has "one of the most firmly established and accepted community corrections programs in the country." There are fewer commitments to the jail today than 5 years ago, despite the fact that the country has the fastest-growing population in the State. Not surprisingly, local citizens are very supportive of efforts to help persons who are incarcerated. At the time of the site visit, 50 people were providing various inmate services at the jail without compensation on a regular basis. The jail's Community Service Division was supervising 200 volunteers.

Incoming prisoners are screened by trained correctional officers. As part of the process, the booking officer must complete an emergency psychiatric checklist. Any inmate who answers a question on this list affirmatively will be given a full and immediate psychological evaluation. In addition, counselors interview all prisoners within 24 hours of admission. Both officers and counselors attend periodic in-service seminars organized by mental health staff.

The warden has made the development of internal treatment services a high priority for his administration. He believes that "having a forensic capability is as much a part of our program as security. In fact, it is security. Inmates with psychiatric problems are handled before they become security problems." Indicative of this orientation is the fact that the warden has ordered the director of treatment to act as the shift supervisor of correctional personnel whenever the regularly scheduled supervisor is sick or on vacation.

The cornerstone of the jail's mental health program is a $99,000 contract with a private agency. The agency has two components with separate staffing and budgets: a Family Court Unit based at the county courthouse and a Correctional Services Unit headquartered at the jail. The Correctional Services Unit has a four-part mandate: (1) to provide 24-hour emergency psychiatric care, (2) to conduct court-ordered pretrial evaluations, (3) to offer individual and group therapy, and (4) to consult with jail staff as the need arises. Providing these services are a Ph.D.-level psychologist (32 hours a week), a psychiatrist (19 hours a week), two master's level psychologists (10 and 16 hours a week), and a full-time office coordinator. The jail's director of treatment, who has a master's degree in human services, oversees their work and acts as a liaison with custodial personnel.

The jail also has two full-time and three part-time substance-abuse counselors. Individual and group therapy is routinely available, and, at the time of the site visit, social service staff were being trained to offer marital therapy as well. Twenty-five percent of all inmates receive some form of therapy or adjustment counseling.

If a prisoner needs inpatient psychiatric care, a representative from the Emergency and Court Services Unit of the county Department of Mental Health is advised that a transfer is being considered. The representative advises the inmate of his or her rights, completes the necessary paperwork, and contacts the admitting physician at the State hospital. Local judges reportedly work very closely with jail officials to facilitate the commitment process. Forty-six inmates were hospitalized during 1980. A local hospital is also willing to accept jail referrals, but the warden has chosen not to use it because security there is poor and because there are rarely any problems in getting inmates accepted for treatment at the State forensic unit. A judge who signs the prisoner's commitment order frequently also signs a contempt of court citation, which can be presented to the hospital administrator if the inmate is refused admission.

Of all the jails in the sample, this facility comes the closest to constituting a mental health resource center for community agencies, in that nearly all psychological evaluations required by the county probation department, public defender, and district attorney's office are conducted at the jail. If the person to be assessed has been released on bail, he or she will be directed to report to the jail on the day that the tests are scheduled. The warden approves of this practice: "The jail should not be a warehouse. The current arrangement not only results in the maximum utilization of the jail staff's expertise, but does so in the most efficient manner possible." He concedes, however, that "The concept has gotten us into trouble. We're getting referrals to the jail for some people who have no business here. Some agencies think that we have better programs than are available on the outside." The director of the mental health agency under contract to provide services at the jail agrees: "Judges sometimes send people to jail just to get their recommendations."

Comprehensive Approach

Jails offering a comprehensive range of mental health services both identify and treat mentally ill offenders during their incarceration as well as make referrals to appropriate agencies in the community of those needing ongoing care upon release. These jails view their institutional responsibility for a prisoner's welfare in a somewhat broader context: they take the long-range interests of the person more explicitly into account.

The comprehensive service approach attempts the following: (1) to identify any inmates having serious or potentially serious mental health problems; (2) to monitor the condition of disturbed inmates; (3) to stabilize disturbed inmates in crisis situations; (4) to provide professional mental health care for disturbed inmates when it is realistic to do so; (5) to transfer inmates to a psychiatric facility when inpatient care beyond that available at the jail is required; and (6) to link disturbed inmates about to be released with agencies capable of providing needed services in the community.

Day-to-day programming at jails with a comprehensive range of mental health services does not always differ dramatically from that found in jails where the mentally ill are identified and treated but not referred for postconfinement care. Both types of programs have similar advantages and limitations, and the quality of treatment may be as good at one type of jail as another. It is thus unlikely that facilities with a comprehensive range of services would vary significantly on many of the variables commonly used to measure program effectiveness or the extent of service impact within the jail. However, by routinely referring inmates whose release is imminent to community mental health agencies, the jail effectively forges a new link with the community mental health network. The continuity of professional care thereby becomes a goal for the jail as well as the mental health system as a whole.

Metropolitan southwest jail. A jail offering a comprehensive range of services was built in the Southwest in 1978 as the result of a court order issued 3 years earlier to reduce overcrowding. It is currently operating within its rated capacity of 342 inmates but is planning a 200-bed annex. The jail is operated by the city under a joint powers agreement with the county. The chief administrator is

appointed by the mayor in consultation with the county manager.

In fiscal year 1981, the jail allotted $162,000 for inpatient psychiatric services and emergency evaluations. This figure represents about 4.5 percent of the total jail budget. Responsibility for the delivery of mental health services is shared by a social worker, who supervises the provision of care for disturbed inmates in the general population, and a nurse, who oversees treatment on the psychiatric ward. Both they and their staffs are employed by a mental health center that is owned by the county but operated by the State university's school of medicine. The director of forensic services at the center views the jail as a legitimate component of a communitywide service network and believes that the jail clientele should have full access to all available care. The chief social worker is also pleased with the arrangement, believing that it results in the optimal use of university resources.

New inmates are screened by officers who receive 80 hours of training in supervision and overall jail management when they are hired. Officers also receive frequent but irregular in-service training organized by staff from the psychiatric unit. Shortly after the prisoners have been screened, they are given a medical examination by one of the jail's two nurses. Anyone who is found to need a psychological evaluation is referred to a part-time Ph.D. psychologist. Prisoners can also be brought to the mental health center for emergency assessments when the psychologist is not on duty. Competency examinations are performed at a special clinic in the basement of the county court building.

Inmates needing treatment can be handled in several ways. Those with the most acute needs are taken to the psychiatric ward of a State prison if they are dangerous or require long-term care. The State forensic unit can be used, but jail officials prefer not to send prisoners there because it is 160 miles away. Inmates who do not pose a security risk can be treated at the mental health center's inpatient unit. Because the jail psychiatrist is employed by the mental health center, he is automatically granted admitting privileges. However, the most common method of dealing with inmates evidencing acute mental health needs is to transfer them directly to the jail's 14-bed psychiatric unit. Space is sometimes problematic, but the infirmary will be

expanded to 34 beds if the design of the proposed annex is ultimately accepted.

Partial hospitalization can be arranged for inmates with less serious impairments. An inmate who is discharged from the infirmary is frequently instructed to return to the unit three times a week for outpatient therapy. Social workers serving the general population also provide instruction in stress management and periodically check for prisoners' problems. Two substance-abuse counselors are available at the jail for consultation as well. Their primary role is to conduct assessments of pretrial inmates and to identify those who could benefit from diversion to a treatment program.

Mental health planning for an inmate's release begins as soon as it is determined that the prisoner needs care. If the person was receiving help from a mental health agency prior to arrest, a request is made for the person's therapist to visit the inmate if at all possible. The therapist also mee. with relevant members of the jail mental health staff so that arrangements for tentative referrals can be on file in the event of a precipitous release. The outside therapist is also asked to maintain regular contact with the inmate and to consult weekly with jail staff so that treatment and dispositional plans can be revised as necessary.

Inmates who are not receiving professional care at the time of their arrest receive case management services from the mental health center's forensic liaison therapist. Upon request from any member of the jail psychiatric unit staff, the therapist will assign a social worker from the center's outpatient unit to work with an inmate. This service is considered to be especially important if available resources do not permit the inmate to receive appropriate treatment while in custody even though the inmate could benefit from specialized care.

Urban far western jail. A comprehensive range of mental health services has also been implemented at a local jail in the Far West. This facility was built in 1975 and has an average daily population of 65 inmates, 5 more than the building was designed to accommodate. The board of supervisors knew when they approved the plans for the new jail that 60 beds would probably be inadequate in light of projected increases in the inmate population. They nevertheless voted to keep the facility small because there was so

much community interest in developing viable alternatives to incarceration. The board also decided to establish a department of correction to operate the facility after a task force concluded that past sheriffs frequently had neither the time nor the expertise needed to manage the jail in the most professional manner possible.

The current administrator is a former deputy sheriff with a master's degree in special education. One of her major priorities has been "to meet the principal physical/social/mental needs of inmates so that prisoners can focus their attention on rehabilitation activities." This jail, therefore, makes a wide variety of educational and recreational programs available as well as extensive mental health services.

Efforts to identify new prisoners who are mentally ill are facilitated by the fact that new correctional officers receive 80 hours of State-mandated training when they are first hired. They receive 24 hours of additional instruction each year thereafter. Both basic and in-service training include instruction in the recognition and management of the mentally ill.

Incoming prisoners are screened by the booking officer and examined by a registered nurse from the county health department. A six-person forensic team from the CMHC also plays a role in the identification process by meeting once a week to determine whether any of the new inmates have previously received professional care from center personnel.

The forensic team staff includes a senior mental health worker, a mental health counselor, and a service coordinator, all of whom work at the jail 20 hours a week. A drug counselor and alcohol counselor each contribute 10 hours weekly and a psychiatrist participates in team activities for 4 hours a week. The team was formed shortly after the new jail opened so that inmate care could be delivered more systematically than had previously been the case when jail officials contacted individual service units at the center on an as-needed basis. Under the new arrangement, forensic team members conduct all nonemergency evaluations, meet regularly to discuss individual cases, and develop multifaceted treatment programs for inmates with multiple problems. Shift supervisors at the jail still call the crisis unit in emergencies.

The county employs private psychiatrists to conduct emergency examinations as the need arises. However, the jail director is very dissatisfied with this approach. A month or two frequently lapses between the date that an examination is ordered and the date it is finally conducted. Several more months may pass before the judge renders a final decision on the issue.

The jail reports little difficulty in transferring inmates who are acutely ill to the State hospital forensic unit or, on occasion, to a prison hospital ward. Correctional authorities nevertheless seek to have an inmate hospitalized only as a last resort. The forensic team coordinator believes that even psychotics know right from wrong, and that those who commit a crime belong in jail, not a mental institution. He stated that when someone from the jail has to be hospitalized, correctional staff feel that they have failed. They take a harsh view of inmates who act out.

Much attention has thus been given to the development of services within the jail so that hospitalization does not become necessary. Both the psychiatrist and mental health counselor who serve on the forensic team offer individual therapy, and the counselor conducts group therapy as well. Group and individual alcohol counseling are provided by a substance abuse specialist who comes to the jail four times a week. Drug abusers can choose from counseling offered by Narcotics Anonymous, the Flower of the Dragon (an organization serving Vietnam War veterans), and twice-weekly sessions led by a staff member from the mental health center. Support groups are also available for the general population. One such group provides "a supportive environment in which participants can air any subject of concern, e.g., the stress of incarceration, separation anxiety, depression, future goals, and substance abuse." Another group is limited to women and "confronts issues unique to incarcerated women." About half of all inmates receive some form of counseling.

Complementing the treatment component of the mental health program are the management and referral services provided by a "community resource team" which meets twice a month. The team consists of a correctional officer, a nurse and a housing supervisor from the jail, two probation officers, a vocational rehabilitation specialist, a job developer, officials from the Community Justice Program and

mental health center, and a representative of two substance-abuse organizations. The team reviews the social and legal status of every inmate held at the jail for more than a few days and develops an action plan designed to help those in particular need of assistance. "Community justice volunteers," who are recruited by the jail to ease the inmates' transition into the community, also help make appropriate community linkages.

Summary

Sorting out the types of mental health programs at the 43 jails studied produced what seemed to be four basic approaches. These approaches were distinguished both by the number and range of mental health services and by the perceived obligations toward the mentally disturbed inmate by the correctional and county officials. To facilitate an understanding of what jails are doing for their mentally ill inmates, the 43 programs were grouped into the four major categories.

Our major research concern, however, was not with a taxonomy of approaches to service delivery. Rather, our primary interest was to analyze how these mental health programs were organized in order to determine where the services were provided, who provided them, and how the jail administration collaborated with the various providers of these services. Also, we concentrated on learning whether any particular arrangement of mental health services was perceived to be more effective than any other and to what extent the different arrangements of service produced more or less conflict in the jail, and greater or fewer problems of interagency coordination. Chapter IV deals directly with these core questions.

CHAPTER IV

EFFECTIVENESS OF JAIL MENTAL HEALTH PROGRAMS: AN INTERORGANIZATIONAL ASSESSMENT

The previous chapter presented a descriptive profile of the mental health services for jail inmates that were available in the 43 study sites at the time of our initial fieldwork. Here our focus shifts from the variety of mental health programs at these jails to a consideration of their organizational properties, that is, who runs them, where they are, and how the various components relate to one another. The central concern is whether the ways services are organized make any difference in how they operate and in their perceived effectiveness. We found from our fieldwork that mental health services for jail inmates can be provided under the auspices of both correctional and community mental health agencies, and that they can be provided within the jail or in external locations. The issue of greatest importance from a program planning and development perspective is whether any one combination of these organizational arrangements is more effective than another.

If the available data suggest that one organizational arrangement is clearly more effective, program planners in communities desiring to develop mental health services for jail inmates would have a single template to guide their efforts. Alternatively, if the data suggest that no single organizational arrangement is superior, program planners must consider the benefits and costs associated with the choice of each organizational arrangement for their specific circumstances such as jail size, the availability of mental health services in the local community, and the adequacy of program resources. At the least, awareness of the problems associated with any one way of organizing jail mental health services can be expected to better inform local planning efforts.

Interorganizational Perspectives on Service Delivery

Instead of viewing the jail as a self-contained or closed system, an interorganizational approach to program development and evaluation looks beyond the jail to its linkages with a variety of other organizations in its environment, such as State mental hospitals, psychiatric units in

general hospitals, CMHCs, and other health and human service agencies. The study of interorganizational relationships recognizes that interdependency is an important reality of organizational life and that organizations seek to manage such interdependency through both cooperative and competitive strategies (Thompson and McEwen 1958; Warren 1967; Warren et al. 1974; Aldrich 1979).

One specific focus of attention has been the area of interorganizational cooperation wherein two or more organizations work together to accomplish their individual operating goals. The structure and dynamics of such relationships have been examined in a variety of health and human service contexts (e.g., Aiken and Hage 1968; Warren et al. 1974; Benson et al. 1973; Lehman 1975). In addition, a growing literature focuses on the larger community context within which organizations interact and environmental "contingencies" influence the level and course of interorganizational development (Whetten 1977). As Schermerhorn (1975, p. 846) points out, this perspective is "a necessary precondition for planned intervention and effective action." Moreover, this line of inquiry has called attention to the proposition that there is "no one best way" of designing interorganizational relationships (Perrow 1970). A variety of linkages can often accomplish particular tasks and goals, and the appropriate structure and intensity of interorganizational relations will depend on environmental features as well as the characteristics of the interacting organizations (Morrissey 1982a).

One promising approach for studying the interorganizational dimensions of jail mental health service programs can be found in the work of Newman and Price (1977a). In the course of a national study of drug treatment in local jails, they found that jails varied widely in the organization and scope of services provided to inmates. A typology reflecting this variability was developed to characterize four alternative organizational arrangements for service delivery: (1) an internal system, (2) an intersection system, (3) a linkage system, and (4) a combination system. These four systems were differentiated on the basis of administrative responsibility and the locus of services.

In the **internal system**, a jail provides all inmate services from within its own organization, and interface with community-based agencies is minimal. The **intersection system** involves services provided by external human

services organizations working cooperatively with the jail. Services are provided (by fee, by contract, or without charge) either by bringing staff into the jail or by transporting the inmates to the community agency. In the **linkage system,** one outside human services agency has direct contact with the jail. The linkage agency serves as an inmate case-finding and referral broker for the human services community. A **combination system** represents a mixture of two or more of the foregoing types. The jail interacts with several service providers, and two or more different conduits (including jail staff, outside resources, and brokerage arrangements) provide services to inmates.

Consistent with the "no one best way" principle of interorganizational design, Newman and Price (1977a) suggest that distinct advantages and disadvantages may be associated with alternative service delivery arrangements for local jails. They note, for example, that coordination and security risks are minimized in an internal program when jail employees are the service providers, but the resource demands on the jail's budget are high and problems may be encountered in hiring qualified service staff. Programs based on linkages with external agencies, in contrast, reduce the demand on jail resources (staff and budget) but heighten accountability and coordination problems with external agencies. Programs combining internal and external components are seen as the most complex type. They foster the greatest volume of services but require a high level of resources from the jail as well as from external agencies, they exacerbate coordination problems, and they run the greatest risk of duplication and discontinuity in service delivery.

The comparative advantages and disadvantages of these alternative service delivery arrangements, however, have yet to be empirically assessed. Newman and Price's evaluations are based on qualitative information obtained largely from jail administrators and their staff; no systematic survey of external human service agencies was undertaken in their study. Yet, to the extent that service delivery arrangements are dependent wholly or in part on community human service agencies, an interorganizational data base is required to evaluate the relative costs and benefits of each arrangement.

If differential costs and benefits are associated with alternative arrangements for delivering jail mental health

services, a number of considerations have to be balanced in choosing an optimal program configuration for any given jail. Newman and Price (1977a) identified jail size, resource availability, and administrative efficiency as relevant dimensions. Another crucial factor is the comparative effectiveness of each service delivery arrangement. In general, although issues of service outcome and clinical effectiveness ultimately depend on client-based epidemiological and experimental research (e.g., Attkisson et al. 1978), studies of the perceived effectiveness of alternative service delivery arrangements can yield important insights for program planning and development.

Certain service delivery arrangements also may minimize problems of interagency conflict, while others may exacerbate them. Moreover, interagency conflict may vary independent of perceived-effectiveness. For example, programs that experience high levels of conflict might still be viewed as highly effective, whereas more placid programs might be seen as being relatively ineffective by some observers or participating agencies. Organizations, including jails, which attempt to mobilize available resources must coordinate activities with other agencies even in the richest of community environments. At the same time, conflict is a near-ubiquitous feature of interorganizational relations. Conflict may be particularly pronounced in those arrangements, such as between jails and human service agencies, which are often thought to have disparate goals and philosophies with regard to inmate custody and rehabilitation. Quantitative data on the prevalence and extent of variation of these problems can yield important information for assessing the costs and benefits of each type of jail service delivery.

In view of these considerations, this chapter focuses on the relationships between alternative interorganizational arrangements of jail mental health programs, their perceived levels of interagency conflict, and their perceived effectiveness. As presented in figure IV-1, our conceptual model for analyzing these issues consists of two parts: (1) the structural antecedents of perceived interagency conflict and (2) the impact of conflict and the structural variables on the perceived effectiveness of jail mental health programs. The model suggests that interagency conflict is a function of program auspices and location, and that program effectiveness, in turn, is a function of auspices, location, and conflict.

Measurement

The data on program arrangements considered in this chapter were gathered during our initial site visits to each of the 43 jail mental health programs in 1981. Semistructured interviews were conducted with sheriffs and jail administrators, mental health service chiefs within the jail (if any), staff from external mental health agencies, and county executives or their designees. These interviews provided the structural data on each jail (size, program auspices, and program location), plus other information about the availability of the inmate mental health services described in chapter III.

The perceived effectiveness, conflict, and coordination data were obtained from a survey instrument mailed to all persons interviewed during the site visits, as well as to others whom they had nominated who were familiar with the jail and its mental health services. This questionnaire asked a series of close-ended questions about the effectiveness of the local jail's mental health program and the extent of conflict among participating agencies. Research staff developed perceived-effectiveness items on the basis of three pilot site visits in New York State; conflict items were adapted from a survey instrument developed by Van de Ven and his associates to assess interorganizational relationships (Van de Ven and Ferry 1980). The 584 forms that were mailed produced 398 responses (68 percent) from the 43 sites. No usable responses were returned from one site, reducing the total number of sites to 42. Of the respondents in these 42 sites, 138 (35 percent) were employed by jails and 260 (65 percent) were affiliated with external mental health agencies. Four distinct staff groups were identified: jail mental health staff (n=52); jail correctional staff (n=86); CMHC staff (n=124); and staff in a variety of other organizations such as State mental hospitals, general hospitals, and drug/alcohol agencies (n=136).

A preliminary analysis of the program-level data indicated that the perceived effectiveness items reflected two distinct components (1) a range of safety goals including the prevention of suicides and suicide attempts and reduction of violence in the jails; and (2) a range of service goals including the provision of appropriate and timely mental health care to jail inmates (Morrissey et al. 1983). Measures of the perceived effectiveness of programs in meeting each type of goal were constructed as scales from the component

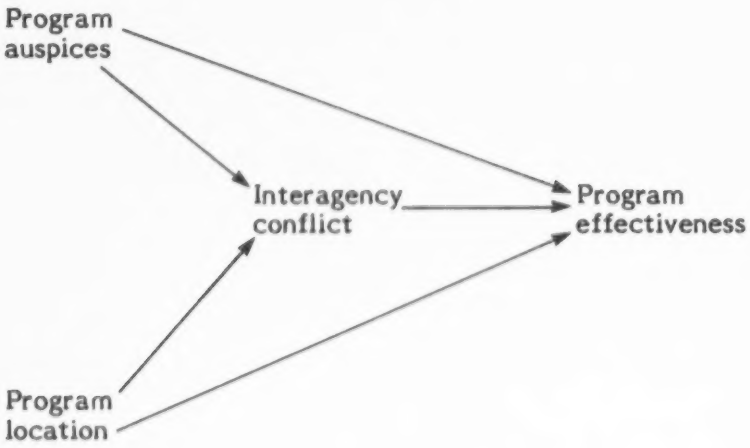

Figure IV-1. Interorganizational model for analyzing the effectiveness of jail mental health programs.

items. An analogous scale was constructed from two questionnaire items to measure levels of interagency conflict.

The auspices and location of each jail mental health program were determined from information obtained during our site visits. Auspices were assessed in terms of the primary administrative control of mental health services (i.e., whether jail, external mental health agency, or a joint arrangement). Similarly, location was measured by the primary physical location of mental health services (i.e., within the jail, at an external agency, or some combination of the two). The distribution of the 42 jail programs across these two dimensions is displayed in table IV-1.

Table IV-1. Distribution of jail mental health programs by auspice and location (N=42)

Program auspices	Program Location*			
	Inside jail	Outside jail	Combination	Total
Jail	4	0	0	4
Mental health agency	7	3	5	15
Joint auspices	12	0	11	23
	23	3	16	42

*The three empty cells were expected because they represent unlikely interorganizational arrangements. For example, a mental health program located entirely outside the jail, yet run by the jail, is quite implausible. Such programs would be run by an external agency and classified in another cell of the table.

The final variable included in the analysis is jail size. Size is a major determinant of differences in organizational structure (Hall 1982). Moreover, our previous work, described earlier, suggests that certain types of mental health services, as well as program auspices and location, are related to jail size. Thus, to ascertain the effects of auspices and location on conflict and effectiveness, jail size was introduced as a control variable. The measure of jail size used here is the average daily inmate population, which ranged in our sample of 42 jails from 19 to 630.

Interagency Conflict

Results of our analysis only partially conform to our conceptual model (figure IV-1). When jail size is held constant, only program auspices seem to affect the level of interagency conflict. Not surprisingly, perceived conflict is moderately high for programs operated under joint auspices. These arrangements entail greater interdependencies between jail staff and external agency staff in serving the needs of mentally ill inmates and presumably allow disagreements to intrude in the service delivery process. In fact, intense levels of interorganizational conflicts were reported at sample sites, and many of the problems stemmed from circumstances specific to individual locations. Two of the more common disagreements concerned the optimal location for delivering services and the jail's lack of payment for services rendered.

Given the realities of severely limited transfer opportunities in State mental hospitals, correctional officials tend to prefer to have as many services as possible provided at the jail to maximize security. Several administrators nevertheless agreed to bring inmates to the mental health center for evaluations or treatment because facilities at the jail were so antiquated. However, some officials indicated that they would do so only if a correctional officer stayed with the prisoners at all times. Directors of mental health agencies generally believed that such an arrangement would violate the principle of confidentiality. At most of the sites where the sheriff would not compromise on this issue, the mental health center ultimately yielded, but a number of directors complained that the procedure requires twice as much staff time as would otherwise be the case. No agreement could be reached in one county, however, with the result that the shift supervisors now ask a local ambulance service to dispatch an emergency medical technician to the jail whenever an inmate needs a psychological evaluation.

The issue of payment was an even more sensitive topic. Few jails had formal contracts with service providers to reimburse them for the cost of delivering inmate care. Mental health centers at three locations billed the inmate-clients directly, but none reported any success in actually collecting. Most agencies were thus forced to absorb all expenses themselves. This was particularly annoying in those counties where the jail was perceived as making unreasonable demands on limited agency resources. The mental health

center at another location stopped doing evaluations for the jail altogether when the sheriff refused to use any discretionary funds to offset some of the related costs. Overall, however, considerably less interorganizational conflict was reported than we had expected at the outset of the study.

Program Effectiveness

The second part of our conceptual model focuses on the perceived effectiveness of the 42 jail mental health programs. Effectiveness is considered in relation to two distinct goals for these programs: safety and service. At issue is the extent to which the conflict and structural variables account for differences in the perceived effectiveness of achieving safety and service goals, regardless of jail size.

Safety Goals

Our analysis showed that, overall, respondents felt that the 42 jail mental health programs were moderately effective in meeting safety goals. However, programs considered to have a good deal of interagency conflict tended to be seen as ineffective in achieving safety goals.

Of the two structural variables, only program location explained some of the variation in safety goal achievement. Relative to programs located inside a jail, those in outside or combination settings received significantly lower ratings on achieving safety goals. And, once the effects of interagency conflict and program location were considered, program auspices were found to have essentially no influence on perceived safety.

An absence of a significant effect for jail size indicates that the mental health programs were rated uniformly effective in achieving their safety goals, regardless of the size of the inmate population. Only when there is much interagency conflict and services are provided either in outside or combination locations are programs rated significantly less successful in attaining safety goals. Furthermore, the absence of a significant effect for program auspices suggests that safety goals are equally well met whether programs are operated by jail staff or by external mental health agencies. Thus, for safety goals, it would appear that the crucial structural factor is **where** the services are delivered, not which agency delivers them.

Service Goals

The results of this analysis showed that the study variables explained about half of the variation in the perceived effectiveness of service goals. Overall, the 42 jail mental health programs were considered only moderately successful in attaining service goals, whereas jail size made a modest contribution. Larger jails tended to be less effective in achieving service goals than smaller jails, but the difference was not significant. Once the effects of jail size were controlled, however, the perceived level of interagency conflict contributes substantially to service goal effectiveness. For example, programs in which there was much interagency conflict were considered ineffective in achieving service goals. Also, programs run by mental health agencies or operated under joint auspices tended to be rated lower in service effectiveness when they were located outside the jail.

These results only partially conform to the proposed model. Other than the modest effect associated with small jails, service effectiveness appears to be related more to levels of conflict than to program location or program auspices. In other words, these findings suggest that mental health programs associated with smaller jails, as well as those with relatively low levels of perceived conflict, are more successful in attaining service goals. Under these circumstances, the volume of service delivery is rather low, and interagency relationships (when present) are relatively benign. Also, the likelihood is high that mentally ill inmates would be provided with an appropriate range of timely services and would be linked to external agencies when they are available in the community.

In summary, these results of our analyses reveal differential patterns of association between the measures of program structure and program effectiveness. Program auspices, for example, seemed to affect only the level of interagency conflict. Programs operated under joint auspices were perceived as having significantly higher levels of interagency conflict than those programs operated by mental health agencies alone. The extent of interagency conflict for jail-operated programs fell between these extremes. Program location was related only to the attainment of safety goals. Mental health programs located inside a jail were perceived as more effective than those in combination or outside settings in achieving safety goals. Finally, with

increases in perceived conflict, the effectiveness of both safety and service goals tended to decrease markedly.

Compatibility of Safety and Service Goals

One of the more important findings that emerged from the foregoing analyses was a rather strong positive relationship between safety and service goal effectiveness, indicating that jail mental health programs which were considered effective in attaining safety goals also tended to be seen as effective in attaining service goals. In short, it appears that both goals are compatible and mutually supportive in jail settings. This finding is notable in light of prior sociological analyses of mental hospitals and correctional facilities, which suggest that therapy (service) and custodial (safety) goals are difficult to attain in the same organization (Parsons 1957; Costonis 1966; Street et al. 1966; Courmier 1973).

At the time we initiated our perceived-effectiveness survey, our research interests focused more on macroorganizational design questions than on custody-therapy conflict issues in the local jail. Consequently, we did not ask respondents to comment on the frequency and scope of day-to-day conflict between correctional and mental health personnel working in our study jails. This issue became much more important as our research unfolded, and a separate survey was mounted to explore these issues. The results of this second survey are reported in chapter V, but we want to explore one aspect of the goal compatibility issue in more detail here.

The foregoing analyses are based on aggregated program-level measures of the effectiveness of service and safety goals. Any differences in the extent to which each of the four staff groups rated the compatibility of these goals would therefore have been averaged out. Accordingly, it is possible that the aggregated measures suppressed significant differences between the mental health and correctional staff involved in the delivery of mental health services to jail inmates. To determine whether such differences were present, we divided our program-level measures into separate scores for each of the four respondent groups.

The effectiveness of jail mental health programs in attaining safety goals was rated highest by the jail correctional staff, followed by CMHC staff, jail treatment staff,

and other mental health agency staff. These results indicate that the four staff groups were not uniform in their ratings. However, only the other mental health agency staff differed significantly from the first three groups. The average ratings of jail correctional, jail treatment, and CMHC staff did not differ significantly. This suggests that although these three groups agreed that the jails in our study attained safety goals quite effectively, other mental health agency staff tended to rate the jails' achievement of safety goals much lower.

One interpretation of this finding relates to the differential involvement of the four staff groups in the day-to-day operations of jail mental health programs. Across the 42 study sites, staff from the mental health agencies were less directly involved in providing services within the jail than were the other three groups. Respondents from these "other mental health agencies" include forensic staff from State mental hospitals, treatment staff from local general hospitals, and a number of administrative or planning staff from State and county mental health agencies. In general, these respondents are involved with jail inmates only in a segmental or indirect way (e.g., through offsite evaluations at local and State hospitals or through planning and administrative activities). Hence they tend to be less familiar with day-to-day programming and are undoubtedly less sensitive to the impact that mental health services have on inmate and staff behavior in the jail. In contrast, the three groups most directly involved in onsite service provision tend to concur that mental health services do enhance the attainment of safety goals.

With regard to the perceived effectiveness of jail mental health programs in achieving service goals, our results showed a similar lack of uniformity among the four respondent groups. CMHC staff had the highest rating on service effectiveness, followed by jail treatment staff, jail correctional staff, and other mental health agency staff. However, the only significant difference was between the CMHC staff and the other three groups. This suggests that although the CMHC staff felt that the jails in our study were quite effective in attaining service goals, the jail treatment staff, jail correctional staff, and other mental health agency staff considered the success of these programs to be substantially lower.

Further insight into these effectiveness ratings can be obtained by examining the differences between subgroup averages on safety and service goals. Overall, the average rating on safety goals is significantly higher than the average rating on service goals. This difference holds for each of the respondent subgroups, although it is not significant for CMHC staff. In general, these comparisons indicate that respondents believed their jail mental health programs were more successful in attaining safety rather than service goals. Qualitative data obtained during our site visits suggest that this difference can be attributed, in part, to program priorities and to the relative opportunities for accomplishing each goal in jail settings.

In setting program priorities, both correctional and mental health personnel tended to define safety goals as the first concern. In field interviews, when jail correctional staff were asked to comment on the value of mental health services, they usually responded in terms of safety goals (e.g., suicide and violence reduction). In general, these staff described the value of mental health services in terms of "keeping the lid on" the jail and maintaining inmate security.

Mental health staff also place high priority on safety goals. In field interviews they often acknowledged that traditional therapeutic goals involving long-term treatment and personality change were unrealistic for the most part in a jail setting. With overcrowding and the rapid turnover of inmates, they were oriented toward early identification, segregation from the general population, and crisis stabilization, usually involving psychotropic medication.

In terms of safety goals, then, there appears to be a convergence of interest between correctional and mental health staff. These goals can be reasonably accomplished by providing adequate space for the segregation of mentally ill inmates and having mental health personnel available for their care and supervision, either as part of the jail staff or from outside agencies. The relatively high ratings on safety goals suggest that the jail mental health programs included in this study were relatively successful in this regard.

Nevertheless, the ratings on service goals indicate that the jail mental health programs considered here are much less successful in providing inmates an appropriate range of services, outside hospitalization, or placement in community programs at release. Although these goals tend to be more

central to mental health than to correctional staff, their accomplishment necessarily requires resources beyond those that can be provided by the jail. Given the underfunding of community-based programs in most localities, there is little enthusiasm for programs that would preferentially funnel resources to jail inmates. In the public's view, the "worthiness" of jail inmates to receive special treatment is often questioned. This feeling is exacerbated by the reluctance of community general hospitals and other service agencies to develop programs for jail inmates because they represent both a drain on scarce resources and a threat to the integrity of their services. Furthermore, the jail inmate is a county responsibility in most jurisdictions, and State agencies are often reluctant to assume this responsibility in the face of the revenue constraints and escalating costs associated with prisons and mental institutions. Thus, the discrepancy between safety and service goal accomplishments in jail mental health programs can be attributed in large part to the status of the wider community mental health service delivery system rather than to differences intrinsic to the jail programs themselves.

Discussion

The findings presented in this chapter are consistent with those of previous studies of interorganizational relationships and point to a number of issues for further research. Overall, no single structural configuration of jail mental health programs achieved high ratings on the effectiveness of service and safety goals while also having low ratings on interagency conflict. Rather, a number of tradeoffs appear to be associated with each interorganizational arrangement. A program that concentrates on providing services to inmates outside the jail by mental health agencies, for example, seems to reduce the level of interagency conflict, but the price appears to be decreased effectiveness in attaining safety goals. In contrast, a program run by jail staff inside the jail would seem to enhance the attainment of safety goals, but the price appears to be a higher level of interagency conflict when the jail does interact with outside agencies for mental health services. Moreover, a program run inside the jail may not be a viable option for all communities. Internal programs make heavy demands on the jail's physical plant, specialized staff, and operating budget, and the inmate population must be large enough to justify the program expense (Newman and Price 1977a).

Programs that rely on both internal and external components reveal yet another pattern of benefits and costs. By pooling scarce resources, those programs operated under joint auspices may expand the range of mental health services available to inmates while diminishing program costs to participating agencies. However, such arrangements appear to promote high levels of interagency conflict which, in turn, are associated with decreased program effectiveness in meeting safety and service goals.

Thus, what was suggested at the outset by the general interorganizational literature (Perrow 1970; Whetten 1977) is strongly supported by these findings: there is "no one best way" to organize jail mental health services. Our study has identified several contingencies that need to be considered in developing an optimal organizational arrangement for jail mental health programs, such as the availability of external mental health agencies, the auspices under which the program is operated, and the program's location. Moreover, the extent to which sponsors and participants are willing to tolerate interagency conflict and the extent to which conflict is detrimental to jail operations are crucial factors to be considered in designing such programs.

Despite low overall levels of interagency conflict, our findings indicate that conflict tends to increase when mental health services are provided under joint auspices within the jail. Because these arrangements call for the most intensive contact between correctional and mental health agency staff, the resultant high levels of conflict support arguments advanced by Hall et al. (1978) that interorganizational conflict is a function of the intensity of relationships between agencies. Furthermore, our results on the compatibility of safety and service goals for local jail mental health programs appear to contradict the idea that each goal cannot be effectively attained in local jail settings. (As noted earlier, however, we focused more directly on the question of **day-to-day conflict** between correctional and mental health personnel as part of our second survey of the 43 mental health programs, and a fuller assessment of these issues is presented in chapter V.)

On a practical level, our overall findings from this phase of the research highlight the dilemmas of mounting appropriate service arrangements for mentally ill persons in local jails. Although efforts to reduce the size of jail populations and to enhance mental health services in jails might

seem to be the best policy objective, the current fiscal distress of county and State governments may well preclude the level of appropriations necessary for their implementation (Janovsky et al. 1982; Rawls 1982a). Moreover, policies geared toward expanded linkages with existing community mental health agencies may founder on the resistance of these agencies to deal with persons who are ostensibly "mad as well as bad." Lamb and Grant (1982), among others, have noted that the current system of voluntary community mental health care is inadequate for this population who are extremely resistant to it. Effective strategies for dealing with this population may require new or hybrid institutional arrangements that offer treatment in a structured and protective environment. Short of such fundamental realignment in the roles and jurisdictions of the mental health and criminal justice systems, local jails will continue to be faced with the challenge of meeting inmate mental health needs for the foreseeable future. Although formidable in their own right, these challenges are only a part of the broader problems of providing shelter and humane care for chronically mentally ill persons in the community (Tessler and Goldman 1982).

Although our findings illustrate the relevance of an interorganizational perspective for understanding the scope of these service delivery issues, our research on program effectiveness has dealt only with the perceptions of correctional and mental health personnel directly involved in a relatively small sample of jail mental health programs. Clearly, further research is needed to replicate these findings for a larger probability sample of local jails. Moreover, it would be extremely useful for program planning and evaluation purposes to design studies of the effectiveness of jail mental health services based on behavioral indicators of inmate outcomes. Such research would help to determine whether programs perceived as effective in meeting safety and service goals actually result in better client outcomes in terms of symptom stabilization, higher levels of community adjustment, and stable participation in community mental health services.

Nonetheless, the insights gained from our current work underscore the fact that the way jail mental health services are organized does make a difference in how such programs are evaluated by both mental health and correctional personnel. Knowledge of the trade-offs involved in different arrangements of program auspices and location can make

local planners aware of the problems likely to emerge under each arrangement. To the extent that such problems can be anticipated from the outset, corrective or preventive measures might be developed to forestall, mitigate, or avoid them.

CHAPTER V

SCOPE AND FREQUENCY OF CONFLICT BETWEEN MENTAL HEALTH AND CORRECTIONAL STAFF

Our attention shifts in this chapter from a focus on the compatibility between safety and service goals and the conflict that may occur between mental health and correctional staff over these goals, to the scope and frequency of day-to-day conflicts between correctional and mental health personnel in our sample of 43 jails. In chapter IV we reported that the results of our perceived effectiveness survey suggested that safety and service goals were highly compatible in jail mental health programs. However, we recognized that more direct measures of differences emanating from the potential therapy-custody conflict were needed to fully answer questions about the compatibility of mental health and correctional personnel in local jails.

When our research began, we had no intention of focusing on internal staff conflict. Our frame of reference was interorganizational. However, as the site visits to the 43 jails progressed, project staff were continually struck by the frequency with which correctional staff, both administrators and frontline officers, commented that the mental health staff had made their job easier. On the other side, although mental health staff often complained about trying to do their job in a jail, they also had an overriding satisfaction in providing needed services in a receptive environment. Because of the discrepancies between our initial expectations on these issues and our onsite impressions, we developed a questionnaire on sources of conflict in the day-to-day operations of jail mental health programs that was mailed to most of the jail and mental health staff members about 18 months after the original site visits. The results of these questionnaires reinforced our fieldwork impressions and organization-level findings reported in chapter IV. Both sources of data contrasted sharply with the ideas found in previous discussions about the delivery of mental health services in correctional settings.

Prior Research on Custody-Therapy Conflict

It has become almost axiomatic in sociological analyses of interactions between mental health and criminal justice

personnel to assume that their respective ideologies are inherently contradictory. The pervasiveness and immutability of conflicts between rehabilitation and custody orientations are usually viewed as determinative of effective mental health services in correctional settings. The classic statement of such conflicts facing mental health professionals in the criminal justice system is perhaps the 30-year-old observation of Powelson and Bendix (1951, pp. 77-78):

> The only professional group which comes into the prison for positive reasons is that of the custodial employees. They enter the prison with the clear objective of punishing convicted offenders and protecting society. Perhaps members of the other professions (doctors, psychologists, teachers, vocational counselors, and many others) enter the prison for equally clear reasons, for instance, to promote the rehabilitation and the health of prisoners. Yet, they cannot, in fact, pursue this goal.... Custody looks at the activities of the other divisions as evidence of misguided humanitarianism. It will tolerate them only after it is satisfied that every conceivable breach of security and discipline has been guarded against. The guards suspect the other divisions of being "soft."

This perception of clashing ideologies that produce enduring conflict between correctional and mental health staff in prisons has been supported in a number of papers (Cormier 1973; Cumming and Solway 1973; Kaufman 1973; Roth 1980) and empirically documented in juvenile detention facilities (Zald 1963; Street et al. 1966; Perrow 1966). Also, a parallel theme of custody-therapy conflict emerging from sociological analyses of State mental hospitals (Parsons 1957; Costonis 1966; Perrow 1965; Steadman et al. 1978) is that such facilities have a dual nature, namely, manifest treatment aspirations coupled with latent social control functions.

Both the sociological analyses of State mental hospitals and the research on the delivery of mental health services in correctional settings strongly suggest that, because of technological imperatives, custody and control functions routinely tend to displace therapeutic goals in dual-mandate organizations. Since the technology of

custody far outstrips that of treatment, and the measurability of outcomes is so superior for custody, it is assumed that custody considerations inevitably predominate whenever a facility has these dual mandates. As Costonis (1966, p. 81) noted, "Custodialism depends upon a simple policy of containment which is relatively easy to implement and to measure. Treatment, on the other hand, places the issues of evaluation back into the problems of type and kind of therapeutic practices and the difficulties of measurement."

Because the applicability of these custody-therapy analyses of State prisons, juvenile detention facilities, and State mental hospitals to local jails had not been determined before we began our research, we had little information to suggest that they might be different. In fact, the correctional literature, without specifying any particular type of facility, argues the thesis that "conflict between custodial and professional staffs is one of the major administrative problems in the field of corrections" (Culbertson 1977, p. 28). Yet our informal interview data revealed very little conflict in the basic goals of correctional and mental health staff at our sampled jails.

The similarity of correctional and mental health staff viewpoints that were heard on our site visits is evident in the following responses from an administrator of a large urban jail and the director of a mental health unit in another large urban jail concerning the value of jail mental health services:

> We don't expect to cure mentally ill inmates. Our aim is to keep them safe so that they are no worse than when they came in here.... From an operations perspective having mental health services in the jail has made a big difference by reducing assaults, suicides, sexual harrassments, and arson.
>
> We just don't have the luxury of long-term therapy here. Mental health services for this population need to be quick, effective, and appropriate. We try to encourage medications and to stabilize them quickly. After they are settled and quiet, we can then focus on discharge plans ... either getting them back into the general population or into an outside hospital or some other appropriate program.

Despite the number of times we heard such views, we remained skeptical, given the consistency of the sociological and correctional literature on these issues. One explanation we considered was that an interorganizational perspective and our interview schedules were not sufficiently sensitive to these types of conflicts. Furthermore, it was possible that, on ideological grounds, mental health and correctional staffs had little conflict, but that in day-to-day interactions there was substantial conflict. Such a distinction would be consistent with Pondy's (1969) distinction between **frictional conflict**, which is relatively minor and does not alter the organizational structure, and **strategic conflict**, which is deliberately created to permit weak members to force powerful members to relinquish control. Since strategic conflict is not crucial to our analysis, we wish to distinguish between **frictional** conflict and **goal** conflict, as discussed in chapter IV with reference to safety and service goals.

As previously noted, our site visits and the interorganizational measures demonstrated surprisingly little conflict on fundamental goals between mental health and correctional staff. Both groups were committed to keeping the inmates safe from themselves and each other, as well as to protecting staff from bizarre, assaultive inmates. As one district attorney observed, "The goal of the jail (correctional) staff is to 'keep 'em safe.' The mental health services need to be quick, effective and appropriate. They need to prevent deterioration and injury to self or others." This view is entirely consistent with that of the jail psychologist who said that "the treatment goal of our mental health program is to get them to adjust to being incarcerated."

The consensus that seemed to exist on basic mental health goals left untouched the question whether substantial frictional conflict might exist in the day-to-day operation of the jail. Previous sociological analyses of custody-therapy conflict have not found such a distinction necessary for the organizations examined. In the prisons, juvenile detention facilities, and even State mental hospitals of the 1950s and 1960s, the custodial and therapeutic ideologies were so sharply divergent that conflict was inherent. Powelson and Bendix even asserted that "the prison psychiatrist must come into conflict with the custodial treatment of prisoners if he follows the precepts of his profession" (1951, p. 80). This situation, however, may be quite different for jails in the 1980s. If this is the case, not only would some

refinement of the custody-therapy concept in future analyses be suggested, but also the familiar pessimism from the fields of psychiatry and psychology about the ability of mental health services to provide effective services in correctional facilities would be challenged.

Our research approach to these questions involved a mail survey of mental health and correctional staff in the 43 jail mental health programs. The survey instrument was composed of 23 statements designed to tap a range of conflicts that might occur in a jail with an ongoing mental health program. The items were developed from site visits and interviews with mental health and correctional staff. The individual items were factor-analyzed to produce two "frictional" conflict scales. The relationships of these scales to a number of organizational and staff characteristics of each jail mental health program were examined. Ultimately, the relationships of staff characteristics to levels of conflict suggested that a distinction between frictional and goal conflict was important to accurately depict custody-therapy tensions in correctional mental health settings.

Measurement

To obtain a more direct measure of the "frictional" conflict in these programs, a survey instrument was pilot-tested, revised, and mailed in early 1982 to those persons who responded to the original survey at the 43 jails. An initial mailing of 345 questionnaires to those persons directly involved in the jail mental health services produced a response rate of 51 percent. Two followups increased the final response rate to 67 percent (232). This sample was more targeted than the perceived-effectiveness survey discussed in chapter IV, because the types of conflict of interest here were limited to circumstances in which mental health and correctional staff directly interacted.

Although responses were anonymous, it was possible to identify the jail program with which the respondent was affiliated. From this information it was determined that the respondent sample was unbiased. A breakdown by jail size, program location, and program auspices yielded only one significant difference between the respondent and nonrespondent groups. More respondents than nonrespondents were from small jails (18 percent and 7 percent,

respectively), but small jails were slightly underrepresented initially, so no major interpretive problem was apparent.

The eight-page questionnaire focused on a variety of areas, but for our purposes the core items were 23 questions focusing on specific day-to-day issues that might be sources of conflict between correctional and mental health staffs. The questions inquired about such things as "mental health staff access to inmates," "inmates being placed on the mental health tier without mental health staff approval," and "recommendations of mental health staff orders being overridden by security staff." The items were developed by making site visits to two nonsample jails and by pilot-testing an earlier version of the questionnaire with correctional and mental health staff at one of these jails. To ensure confidentiality and maximize candid responses, the only identifying information sought was the name of the jail, the respondent's position, and the respondent's employer.

The initial examination of the 23 items was factor-analyzed to reduce the number of dependent measures of conflict. Based on this analysis, two factors were found to account for 32 percent of the variation in conflict, and additive scales were created by summing the items with high loadings on each factor. The first scale, labeled Treatment, was composed of the following five items that dealt with conflict in the day-to-day delivery of mental health services in the jails: access to mentally ill inmates; delays encountered by mental health staff in getting around the jail; overriding of mental health recommendations by security staff; failure of correctional officers to follow up mental health recommendations; and resistance to the transfer of mentally ill inmates to special housing units.

Several examples of treatment-related conflict were observed during the site visits. Counselors in a substance-abuse agency at one site stated that their regularly scheduled weekly meetings with inmates were frequently cancelled at the last minute because there were reportedly not enough deputies on duty to provide adequate security in the area of the jail reserved for programming activities. Mental health center personnel at another site reported considerable irritation over the fact that when they responded to jail requests for assistance, the shift supervisor would often forget to advise the officer controlling jail admission that such a request had been made. A center psychologist would then have to stand for several minutes in a small waiting

area while the officer obtained authorization to let him enter. A related, but separate source of friction at many locations was the insistence of correctional officers that mental health center staff go through a metal detector and have their briefcases searched every time they went to the jail. Mental health personnel felt that this procedure constituted needless delay and inconvenience, especially since they had already demonstrated their trustworthiness on security matters during numerous prior visits.

The second scale, which we called Role, seemed to tap some type of role infringement as measured by items such as the mental health staff's requesting privileges that run counter to established jail procedures, pampering inmates, and getting involved in jail business, and the correctional officers' requesting mental health records inappropriately. This type of conflict was evident between two employees of a CMHC in a large southern county. One was a Ph.D.-level psychologist who had been assigned to work at the jail on a full-time basis by the center's court services unit. His official responsibilities consisted primarily of conducting evaluations and facilitating the transfer of psychotic inmates to inpatient facilities, although he also prescribed psychotropic medication in cases of emergency. He was able to do so because the jail physician had given him a number of signed but otherwise blank prescription forms to use when the doctor could not be located. A psychiatrist from the adult outpatient unit of the mental health center learned of the practice as a result of his occasional consultations at the jail and openly condemned it as being unethical, illegal, and potentially quite dangerous. The psychologist, in turn, saw the psychiatrist as basically inept and out of touch with many of the more pressing needs of jail administrators.

As in chapter IV, the independent variables examined were program auspices, program location, size of jail inmate population, and respondents' profession and agency affiliation. Auspices reflected the agency that has primary administrative control of the services (viz., the jail, an external mental health agency, or a joint arrangement). Location referred to the actual location of the jail mental health program (viz., inside the jail, outside the jail, or a combination of the two). Size was the average daily census in the jail, which was categorized as small, medium, or large. Respondents' profession was indexed by their actual position/job title at the time of the survey and consisted of

seven categories of various correctional and mental health positions (viz., sheriff/deputy, psychiatrist/M.D., mental health administrator, nurse, psychologist, social worker, and mental health therapist). Affiliation referred to the respondent's employer, which in most cases was the jail, a county mental health agency, or another mental health agency.

Issues Producing Staff Conflict

Consistent with our earlier field interviews, the level of "frictional" conflict for both mental health and correctional staff was relatively low on both the Treatment and Role conflict scales. The only significant relationships between any of the independent variables and the two conflict scales were respondent's profession and affiliation on Treatment conflict. The Role conflict scale was not significantly associated with any of these variables.

An examination of the organizational variables produced a few additional significant findings. With regard to jail size, it was found that size alone was not significant in accounting for differences in Treatment conflict. However, for those programs located in the jail, there was a significant difference in the amount of Treatment conflict between small and medium-size jails. In these internal programs, staff in small jails perceived a far lower level of conflict than did staff in the medium-size jails. Overall, while the differences were not significant, staff in medium-size jails had the highest score on the Treatment conflict scale, followed by those in large jails, with the lowest score in the small jails.

Staff profession and affiliation variables were considerably more important than organizational variables. The relationship between Treatment conflict and respondent's position, for example, was found to be significant. "Other mental health therapists" reported the highest amount of Treatment conflict, whereas sheriffs and deputies reported the lowest level. Moreover, the three groups of Treatment staff (viz., those working in jails, mental health agencies, and other mental health agencies) were significantly different in their perceptions of treatment conflict. Jail staff scored the lowest on this scale, with county mental health staff scoring slightly higher. But the highest level of conflict was perceived by the other mental health group

composed primarily of staff from drug and alcohol counseling agencies and some State mental health facilities.

Although these differences were statistically significant, we also wanted to explore possible substantive distinctions between jail correctional staff and jail mental health staff. If, in fact, the previously discussed custody-therapy differences were at all applicable to the local jail, the highest conflict might be expected among those mental health personnel who worked full-time inside the jail. To test this possibility a variable was created consisting of four staff categories: jail correctional, jail mental health, county mental health, and other mental health. Once again, results with the Role conflict scale were not significant. However, this staff categorization was highly significant in explaining differences in Treatment conflict. This result was to be expected, given the previous separate analysis of position and employer. Jail correctional staff perceived the lowest level of conflict in providing treatment to jail inmates, while jail mental health and county mental health staff reported an equal and slightly higher amount of conflict. The most substantial difference was between the other mental health agency staff and correctional staff.

These results, showing occupational differences in the amount of conflict perceived by correctional and mental health staff, suggest the presence of "frictional" conflict not evident when the focus was on generic goal conflict. These frictional conflicts are less consequential than conflicts for accomplishing organizational goals, and they do vary by type of mental health staff. On the basis of these results, it appears that prior discussions of custodial-therapeutic issues did not achieve the level of specificity that the local jail of the 1980s apparently requires.

Discussion

Two major empirical conclusions emerge from these analyses of day-to-day conflict in the delivery of mental health services in local jails. First, the overall level of conflict in mental health service programs for this type of correctional facility is less than would be suggested by the prison and State mental hospital sociological literature. Second, differences found in the amount of conflict reported by security staff and mental health staff are not found when conflict measures focus on organizational goals. From these

empirical conclusions a number of practical and substantive implications follow.

When staff members in jails that had ongoing mental health programs were asked about day-to-day conflict between the custodial and therapeutic staffs, the amount reported was quite low. This may at least in part be attributable to the fact that jails have a correctional mission very different from that of prisons, and one that is less divergent from mental health goals than that of prisons. In contrast to prison settings that are long-stay institutions, the average length of stay in U.S. jails in 1982 was 11 days (Bureau of Justice Statistics, 1983). Especially in terms of safety goals, there is a convergence of interest between correctional and mental health staff in local jails. The goal of reducing inmate violence to themselves and others can be reasonably accomplished in most jails by proyiding adequate space for the segregation of mentally ill inmates, by having mental health personnel available for their care and supervision, either as part of the jail staff or from outside agencies, and by dispensing psychotropic medication. Moreover, the relatively high effectiveness ratings on safety goals reported in chapter IV indicate that jail mental health programs are able to accomplish these objectives with minimal custody-therapy conflict. As such, there is little support here for the thesis that correctional and mental health staff in jails operate from fundamentally opposite and antagonistic perspectives. While mental health staff tend to be annoyed when their services are defined as a means to the end of secure custody, they nevertheless do place a high priority on safety goals.

The objectives of keeping themselves safe from violent inmates and keeping inmates safe from themselves and from other inmates are uppermost in the minds of the custodial staff. In many instances mental health professionals can clearly contribute to these goals. In doing so, the mental health staff practice their craft of crisis intervention and stabilization in ways that protect both the inmates under treatment and other persons in the jail. Accordingly, the ideological conflicts that might be expected where mental health efforts seek major personality changes are not present. These latter goals may be more typical of correctional institutions (prisons and juvenile detention facilities) where earlier analyses of the custody-therapy conflict were conducted.

Nonetheless, although there are few apparent conflicts in goals between custodial and therapeutic staff in local jails, conflict does exist in some areas involving day-to-day procedures. We have suggested that Pondy's concept of frictional conflict accurately depicts issues in these areas. This distinction between more generic organizational goals (or strategies that may involve reallocation of resources to achieve these goals) and more mundane sources of conflict is significant in refining sociological conceptualizations of custody-therapy conflicts in organizations with these dual mandates. It is thus inadequate to take at face value what appear to be two conflicting paradigms. In fact, in certain types of organizations, such as the local jail, the goals of custody and therapy converge. Both share the primary purpose of keeping the client safe--from himself or herself and from other inmates.

The convergence of goals in this instance appears to be related to two factors: (1) jails are involved in short-term people processing and (2) the technology of mental health treatment for this short-term organizational mandate is more developed than that for longer-term mental health treatment goals. The main mission of the local jail is to deliver these people, as one respondent noted, "no worse than when they came in here" to the court for arraignment, pretrial hearings, adjudication, or sentencing. In most States, the local jail houses persons sentenced to stays of less than 1 year. The jail is a high-turnover organization, so mental health treatment staff cannot get involved in long-term therapy. Their chief task is to stabilize highly agitated or severely depressed persons who present high risks of committing suicide or attacking other inmates or jail staff. These acute situations are stabilized quite dramatically through psychotropic medications and segregation from the general population. In some instances efforts are made to counsel the inmates and to refer them to services in the community, when these exist. Long-term therapies geared to major personality changes that characterize "people-changing" organizations (Hasenfeld 1972) are rarely attempted. Because rehabilitation in the traditional sense is a minor goal for mental health staff, who are more concerned with crisis stabilization, basic ideological conflicts with correctional staff are infrequent and occur much less often than do frictional conflicts.

Obviously, the technologies for these mental health short-term goals are quite well developed, not unlike the

technologies of custody. Thus, in the instance of mental health services for local jails, the conflicts that may be produced by the huge ascendancy of one type of technology (custody) over the other (therapy) is greatly diminished. As a result, there is less conflict in the sphere of ideology and organizational goals. Nonetheless, frictional conflict, which is found in any organization, does exist. Thus, discussions with jail staff will elicit complaints about conflict between the custodial and mental health staffs, but the conflict does not produce an antipathy that precludes attainment of the mutual goals of both staffs.

All this is not to say that other approaches to mental health treatment, if employed in the jail, would fail to generate considerable conflict. As one psychologist noted, "There is little conflict because nothing is being contested. If mental health professionals tried to do real treatment, then real conflict might develop. The jail recognizes this and recruits accordingly. There are mental health professionals who can't work in the jail." Reinforcing this point, an administrator in another jail said, "To the extent that mental health staff are seen as managing the inmate, conflict will be less. We are all doing the same thing. The frontline officer sees the mental health staff as 'helping me to do my job better'." Consequently, as aptly described by a psychologist, "Very rarely do we come into conflict about goals, especially safety and management, (although) sometimes about means."

The bottom line for many mental health professionals in this environment is to view the jail rather than the individual inmate as the client. To the extent that some crisis intervention or regular prescription for psychotropic medication keeps the inmate calm and quiet, the inmate is better off and so too is the entire closed environment of the jail. If individual treatment were more ambitious, much more therapy in the form of individual counseling and group sessions would become more pervasive, and conflict, as well as service costs, would probably increase dramatically. However, given the nature of the jail, such treatment goals are unrealistic while safety management needs are acute. As a result, the mental health professionals willing to work toward less traditional treatment goals can function within the jail with minimal goal conflict.

The results reported here suggest that greater specification is needed in custody-therapy analyses to distinguish

between various types of conflict that occur and to recognize that there are certain types of organizations in which custodial and therapeutic goals converge in ways that permit both types of staff to ethically achieve their respective goals. And in addition to testing the custody-therapy ideas in other organizations, it is also important to note that the facilities and technologies of the 1980s are not those of 20 and 30 years ago when the seminal studies in this area were conducted. These are issues of practical and substantive importance that merit renewed empirical investigation.

CHAPTER VI

FACTORS CONTRIBUTING TO THE SURVIVAL AND DEVELOPMENT OF JAIL MENTAL HEALTH PROGRAMS

The fourth major focus of our research dealt with how well the 43 study jails fared over the period of our project. Given the vast array of external pressures to upgrade services and the tremendous fiscal burdens being shifted to localities during a time of severe economic recession, it was uncertain how this range of jails would survive. Again, it should be noted that this jail sample was not representative of all U.S. jails with mental health programs. Both the 33 sites who had representatives at the 1979 NIC workshops on jail mental health services and the 10 supplemental sites were selected for study because they already had, or soon were expected to have, better than average mental health programs. Thus, the research question focused on what staying power these programs had within fiscally restraining environments.

It was clear from our site visits that mental health programming at many sites was still in a state of transition. Four jails were under court orders or consent decrees to improve the quality of inmate psychiatric services. Similar suits had been threatened or were actually being prepared at several other locations. Even those officials who felt reasonably secure from the threat of a class action suit frequently expressed a concern about the possibility that the family of a disturbed prisoner might seek compensatory damages in court if jail staff failed to detect and treat a serious mental ailment in a timely manner.

To assess changes in the 43 jail mental health programs, officials at the sample jails were telephoned during a 3-week period in the fall of 1982. The length of time between the original site visits and the followup survey varied from 15 to 20 months. Three telephone interview schedules were developed to tap: (1) broad administrative developments, such as changes in the average daily population and facility budget; (2) specific modifications for mental health services at the jail, such as staff turnover, possible changes in the need for psychiatric care, and any problems that were reportedly interfering with the effective delivery of services noted at the time of our original site

visits; and (3) changes in the organizational environment that might have had a direct or indirect impact on the mental health program at the jail, such as as the emergence of a prisoners' rights group, the election of a new county executive, new diversion programs, mandatory sentencing laws, or internal policy changes at county mental health agencies.

At 16 of the 43 sample jails (37 percent), one jail official answered all the questions. These jails were typically very small and had no full-time medical or mental health staff members. Two persons were contacted at each of the remaining 27 sites. The sheriff or his designee answered the first series of questions about administrative changes, whereas the person most responsible for mental health services was asked about substantive programmatic developments. Both were asked about the organizational environment. A total of 70 people were interviewed, requiring nearly 250 phone calls.

Changes in Staff and Service Providers

One of the prerequisites for program development is the employment of qualified staff who can both plan and implement necessary changes. Turnover of key personnel is thus a critical variable. It may have a very positive impact when staff members who have "burned out" or who are not performing effectively are finally replaced, or it may greatly complicate the goal of providing inmates with quality psychiatric care.

It is important to note that mental health services in jail settings may be influenced by the turnover of personnel serving in a variety of roles other than simply psychiatrist, psychologist, and social worker. Nursing staff, for example, usually distribute medication and monitor the condition of psychiatric cases confined to the jail infirmary. Doctors may be called on to evaluate prisoners who have been behaving strangely. In the smaller jails, even correctional officers may be expected to help classify inmates and contact the mental health center when the need arises.

During our original site visits, 50 officers were identified as being directly involved in the delivery of mental health services. Five (10 percent) had left before the followup. No data on the national turnover of jail officers could be found for comparison, but it may be worth

noting that custodial staff in State prisons reportedly have an annual turnover rate of 20 percent (Lunden 1965). In any event, the vast majority of officers who arrange or otherwise provide inmate mental health care retained their jobs during the period under study. Because 38 sites (88 percent) were unaffected by any such shift in custodial personnel, we can reasonably conclude that officer turnover had a minimal influence on programming changes.

Turnover of medical/mental health staff was far more problematic. A list of 263 medical/mental health staff who had provided psychiatric services to jail inmates at the time of our site visits was compiled. Administrators contacted during the second round of data collection were able to confirm the employment status of 239 of these people (91 percent), of whom 67 (28 percent) no longer served jail inmates. This proportion is comparable to the 30 percent annual turnover rate for social workers in State and local welfare organizations (U.S. Children's Bureau 1965) and the 30 to 40 percent rate often cited for nurses (Heilman 1981). Nevertheless, it is still more than double the 13 percent median separation rate found in nonprofit organizations for professional and technical workers generally (Price 1977).

Small jails (average daily population of 50) experienced the least turnover. Only 7 percent of the mental health staff who worked in such facilities had left. Medium-size jails (average daily population of 51 to 250) experienced a 28 percent turnover rate, while 38 percent of the medical/mental health staff had left the large jails. One of the reasons the smaller jails experienced the least turnover is that most mental health professionals assisting these facilities did so on an as-needed basis, and those who worked part-time in the jails were much more likely, as a group, to have kept their positions. Of the 239 staff whose status was verified, 176 (74 percent) were part-time jail employees. Of these, 37 (21 percent) had left. By contrast, of the remaining 63 persons who worked full-time with inmates, 31, or nearly half (49 percent), were no longer there at the time of the followup. This result raises the possibility that burnout may be a serious problem among those whose work involves prolonged daily contact with mentally ill inmates.

A second reason the smaller jails experienced less turnover is related to the occupational stability of the person most responsible for mental health services and its subsequent effect on subordinates. The top mental health

administrator retained his or her position at all of the 8 small jails, at 15 of the 22 medium-size jails (68 percent), and at 7 of the 13 large jails (54 percent). The larger the jail, the more likely the administrator was to have been replaced. The implications of such a development can be seen in table VI-1. At facilities where a new chief of jail mental health services had been hired, turnover was 2 1/2 times greater than that in jails where the director had retained his or her position. Furthermore, turnover was greater regardless of auspices or the amount of time spent with inmates.

Table VI-1. Percentage of medical/mental health staff turnover by turnover of the director of mental health services for jail inmates

	Same director (percent)	New director (percent)
Time with inmates		
Full-time	19	72
Part-time	17	28
Auspices		
Jail	26	61
Mental health	14	35
Total	17	44

A jail administrator offered an interesting perspective on staff turnover during one of our site visits. He observed that for individual inmates and their course of treatment, staff turnover was no problem because inmates typically were in the jail for such a short time. "Inmates don't see turnover. From their perspective, turnover is irrelevant. It is a problem only from the administrative standpoint." Staff turnover thus becomes problematic from a treatment point of view only when continuity is a concern, that is, continuity of direct care of the inmate in the jail to a lesser extent than in the community linked with jail treatment. Where turnover is high, the prospect for staff to know the external mental health system is decreased. However, because such linkages are infrequent anyway, staff turnover is not overly problematic. Furthermore, inasmuch as interventions inside the jail are usually limited to medication and lengths of

detention are usually brief, continuity of care becomes less important.

Program Development

The sample sites experienced few changes in interorganizational linkages between the jail and other community organizations providing services to the inmates, and the changes that did occur were typically beyond the control of local authorities. A substance-abuse agency was closed for lack of funding, a small firm composed mostly of psychologists was reorganized so that staff could spend more time doing research and less providing direct service, and so on. Authorities at several sites attempted major improvements, but they were almost always made within the framework of the existing service network. Accordingly, the development of jail mental health services was less dramatic than had been expected, given the NIC Workshop and court orders. For example, there were no changes, positive or negative, at seven sites (16 percent), and at only four jails (9 percent) were there five or more differences in the ways services were being delivered. All other jails (75 percent) fell into a group with only a few changes.

Small Jails

Programming at the eight small jails was especially stable. At three locations, the services remained the same as they had been a year and a half earlier, both in content and in mode of service delivery. Mental health agencies did assign more staff to work with inmates at the three sites, but most improvements, such as they were, focused on better instrument forms and procedures. New services were introduced at only two facilities. In both instances, the innovation consisted of providing in-service training for correctional staff.

Although existing services did not improve substantially, erosion in programming was minimal. The single instance of service reduction involved a decision to enhance jail security by terminating a weekly counseling session sponsored by Alcoholics Anonymous, but most of the inmates at that site had been given work release status and were allowed to attend AA in the community if they so desired.

The lack of change among the small jails seemed to have stemmed from two factors. First, the level of need was reportedly about the same as it had been at the time of our initial site visits at five of the small jail sites (63 percent) and had actually declined at the remaining three. The reduced need for mental health services was seen as a function of chance in one county ("Just lucky, I guess"). At the other sites, community mental health agencies, which the police had begun using in lieu of the jail, were providing alternative placements for disturbed persons.

The second factor was financial. The mean annual budget for the small jails increased by only $1,000 (from $218,000 to $219,000). This 0.05 percent increase is not even commensurate with the rise in inflation, and officials at two facilities indicated that they had lost Federal grants as well. Administrators thus suffered a net loss of resources during a time when the average daily population rose from 33 to 37 (12 percent). Making arrangements to meet the additional costs generated by housing the extra prisoners (food, medical care, etc.) would almost certainly have to take priority over plans to expand existing services.

Medium-Size Jails

Programming improvements at the 22 medium-size jails were also sporadic. There were no changes at four of the sites (18 percent), whereas a new service was introduced at five jails, the most common one again being in-service training. Two innovations were particularly interesting. At one jail, officials implemented a computerized prebooking screening system to identify mentally disturbed prisoners. As a result, when it appears that the police have brought a mentally disturbed prisoner to the jail, the booking officer notifies the director of services, who then tries to divert the person before admission. The other noteworthy innovation was actually implemented in response to several attempted suicides the year before. Not only were evaluation, therapy, in-service training, and case management services improved, but new inmates are now undergoing a special "suicide detection test" at the time of admission. No other jail in the sample uses such a tool.

The most frequent change among the medium-size jails was in the area of improved forms and procedures. Nevertheless, new medical/mental health personnel were either added to jail staffs or assigned to the jail by local mental

health agencies at eight locations. Following the recommendation of a countywide task force, one jail hired a full-time mental health/mental retardation counselor to act as a liaison with the CMHC. The impact of such staff increases was diminished to some extent, however, by the fact that a greater number of prisoners had been assigned to jail custody. Between the time of the site visit and the followup contact, the average daily population of the medium-size jails rose from 131 to 148 (13 percent). Consequently, those jails that contracted for additional mental health staff time might actually have succeeded only in maintaining prior levels of service. Meanwhile, the 24 sites that did not hire additional personnel may be in a somewhat worse position than they were at the time of our initial site visits.

A troubling development in the medium-size facilities is that a total of ten services were either greatly reduced or eliminated across seven jails. At three of the sites, the losses were directly attributable to budget cuts. The most serious instance occurred when a mental health center could no longer respond promptly to evaluation requests from the jail following staff layoffs. Another situation developed at a site where the director of a mental health center concluded that jail requests for evaluations frequently lacked merit and constituted an unnecessary drain on agency resources. The center thus had stopped honoring requests for inmate evaluations in nearly all except emergency cases. The final example of service deterioration stemmed from a decision by correctional authorities that the jail is simply not an appropriate place to treat disturbed persons. As such, they replaced a master's level psychologist with a social services counselor whose responsibilities include contacting outside agencies to arrange for the treatment of the most seriously ill inmates.

Unlike most officials at the small jails, administrators of the medium-size facilities generally found that the need for mental health care had increased during the previous year and a half. At 12 sites (55 percent), the situation had become "more" or "much more" serious since the time of the site visit. At only one jail had the need declined. Illustrative of this trend may be the fact that inmates committed suicide at only 3 medium-size jails in 1981, whereas 10 such jails experienced at least 1 suicide in 1982.

Community developments posed additional problems for jail administrators. Several respondents cited stricter laws

regarding drunk drivers as a factor that will keep inmate population levels very high for the foreseeable future. State hospital closings have made it more difficult for some jailers to transfer psychotic inmates, and financial cuts at mental health agencies represent an ongoing threat to the amount of staff time that can be reserved for inmates. A new assistant director at one mental health center was reportedly so unsympathetic to jail needs that she was even thought to be considering a complete elimination of jail services from her 1983 budget. The average jail budget, meanwhile, rose by 32 percent (from $1,155,000 to $1,519,000) during the period under study, but the extra funds had typically been appropriated for construction and salaries for new officers. Very little was left over for discretionary service development.

Large Jails

Mental health programming received considerably more attention at the 13 large jails in the sample than at either the small or medium-size facilities. No large site administered the services in precisely the same manner as at the time of our initial site visits. New services had been introduced in 8 jails, 1 more than the combined total initiated at the other 30 locations. In 3 of the 8 cases, staff were instructed to develop a case management program under which mentally ill inmates would be referred to appropriate community agencies for treatment following release from jail. Eleven of the large jails in the sample now have some type of case management program in operation, although many are not aggressively implemented.

It will be recalled that most of the improvement in the small and medium-size jails reported thus far consisted of developing better forms and procedures. By contrast, the single most common improvement in the large jails was the commitment of extra resources to hire more staff. Fifty-four percent of the large jails recruited more medical/mental health personnel, compared with just 38 percent of the small jails and 36 percent of the medium-size facilities. The average daily population rose by 12 percent, however, so once again it must be noted that those jails that maintained prior levels of staffing actually experienced a decline in the number of staff hours available to inmates on a per capita basis.

Individual services deteriorated at three large jails. In one instance, drug/alcohol counseling had to be cut back when the mental health center, which sponsored the program, lost funding. Service reduction at the second jail stemmed from a decision by top correctional authorities to eliminate a therapy program so that resources could be spent on other services that were reportedly in greater demand. The most substantial deterioration, however, occurred at a site that had ironically been under a court order to improve mental health services. The problems started when the jail director hired a person with no specific mental health training to replace a Ph.D. psychologist who had been in charge of both intake screening and psychological evaluations. The situation so alarmed the psychiatrist with overall responsibility for programming that he wrote a letter to the director disclaiming any responsibility for the decisions of his new subordinate.

Respondents at 8 of the 13 large jails (62 percent) indicated that the problems posed by mentally ill inmates had remained about the same. At four locations, the problems were described as "more" or "much more" serious. An official from the one site where problems were reportedly much less serious noted that a county task force had been working closely with the district attorney's office to find alternative placements for disturbed offenders. Community developments at the large jails were almost identical to those reported earlier with regard to the medium-size facilities. The large jails, however, were more likely to have lost Federal grants.

Changes in Specific Services

Table VI-2 presents a summary of the principal changes that occurred in the specific services studied. Only those changes for which local jail or mental health authorities were directly responsible are reported. Revisions in State law, for instance, can obviously have a significant impact on jail mental health services but may not be the result of local initiatives. Similar examples of change that have not been included are the decision to move the forensic unit from one State hospital to another and the easing of a perceived problem for reasons unknown to those involved.

A few of the table headings require some explanation. A service was coded as having been "Initiated" if it was introduced between the time of the site visit and the date of

the followup. Conversely, if a previous service was either no longer available or had been beset by major problems, it was noted in the "Discontinued/Deteriorated" column. A site received credit for "More staff" only if the additional personnel spent a substantial amount of their daily working time providing that service. A new nurse, for example, might assist in the distribution of medication, but if the nurse had been hired primarily to monitor the condition of mentally ill inmates in the infirmary, only "Internal hospitalization" would be coded as having received the extra help.

"Expanded service" refers to any increase in the amount of service provided other than that related to an increase of staff. Accordingly, some changes included very modest improvements. Officials at several jails, for example, added new questions to their screening forms in the hope of identifying more mentally ill inmates at the point of admission. Psychologists at one site supplemented their existing counseling program with special therapy for sex offenders. At another jail, eligibility requirements for case management services were eased so that more inmates could receive referrals to mental health agencies at release.

"Improved procedures" refers to changes in the process by which services are delivered. Typical examples include better communication between correctional officers and mental health staff regarding the need for inmate evaluations, a nurse's placing medication in dosage packets to reduce the likelihood of error when officers distribute it, and a written agreement between jail and hospital officials that clarifies the circumstances under which an inmate can be transferred to the hospital psychiatric ward.

Any remaining innovations were coded "Other." At one site, for example, security was improved for those situations when evaluations had to be conducted at the mental health center. Dissatisfaction with the response time to jail emergencies by a mental health center caused correctional officials at another location to contract with a separate agency for the needed services. A person providing substance-abuse counseling at a third site was replaced by someone who was supposedly much better qualified.

Table VI-2 shows that the fewest developments were in the areas of "Competency" and "External hospitalization." This finding was expected because these two services are the ones over which local jail and mental health authorities

Table VI-2. Program changes in mental health services

Program component	Type of change						
	Initiated	More staff	Improved expanded service	Improved procedures	Other	Discontinued/ deteriorated	Total
Screening	1	3	6	1	1		12
Evaluations		7		5	2	3	17
Competency				1	1		2
Psychiatric medication		5		2	2		9
Drug/alcohol counseling	3	3	2	2	2	7	19
Therapy	2	1	2			4	9
External hospitalization				1			1
Internal hospitalization	1	2	2				5
In-service training	5	3	6		1		15
Case management	3	1	1	2			7
Total	15	25	19	13	9	15	96

have the least control. Changes in "Internal hospitalization" also appear to be minimal, primarily because most of the jails in the sample are too small to offer this service. "Evaluations," "Drug/alcohol counseling," and "In-service training," by contrast, account for 54 percent of all changes. A total of 15 such services were introduced at the sample facilities. Officials at five sites (12 percent) initiated in-service training programs, the single service most commonly changed. Drug/alcohol counseling and case management referrals at release were the next most frequently introduced services.

Overall, the number of initiated services was identical to the number of services that had been discontinued or that deteriorated substantially. **There was thus no net gain in the number of services available to mentally ill inmates.** Officials at seven sites experienced problems with drug/alcohol counseling, and deterioration in this one service accounted for almost half of the overall decline. Funding cuts had an impact on the program at three locations. Officials at two sites felt that such services were no longer needed, and the program was eliminated at two other facilities to improve security. The therapy program suffered at four locations. In two instances, the change reflected a shift in official priorities to the extent that mental health staff were assigned to do other tasks. At the other two jails, the changes were related to staff turnover: psychologists who used to conduct the therapy sessions resigned and either were not replaced or were replaced by persons who lacked the necessary skills. The evaluation process was the only other service that deteriorated at more than one site. One jail lost a Ph.D. psychologist, a mental health center had to reduce service to the jail because of funding cuts, and administrators at another mental health center would not honor requests for evaluations in nonemergency situations.

One-third of all recorded improvements were made in **the screening and evaluation services.** Common innovations in the screening program included changes in the form that is completed during booking, the assignment of professional staff to conduct the screening, and the addition of a medical check or classification component to supplement the information gathered when the inmate is admitted. Much of the improvement in evaluations, by contrast, consisted of obtaining more or better trained staff. Other modifications focused on enhancing security and on reducing

the lag time between the moment an examination is requested and when it is actually performed.

Training was another frequently improved service, although no single strategy emerged. Officials at one jail requested assistance from the State corrections academy, while two of the larger jails hired full-time training officers and officials at two other facilities made new arrangements with local mental health agencies.

Changes in the medication dispensation process typically entailed the hiring of extra nurses, in lieu of correctional officers. At those sites where nurses were not hired, measures were initiated to reduce the number of errors that are sometimes made when nonmedical personnel are called upon to deliver prescribed drugs. One sheriff, for example, designated a special medical officer to work with the jail physician.

Drug/alcohol services were improved at nine sites. Alcoholics Anonymous began working with inmates at two of the three locations where new staff were recruited, so the jail did not always incur new expenses when making this change. Officials at one site expanded the number of weekly meetings available to inmates, but because the sessions were conducted by the same staff members who had previously been involved, there was once again no need for an additional appropriation. Group meetings were supplemented by patient education at another site, and, in one jail, better qualified personnel were recruited to replace the existing staff.

None of the remaining five services was improved at more than four sites. As previously noted, authorities have little control over the competency and external hospitalization process, and only a few jails in the sample were large enough to hospitalize inmates onsite. Officials would, of course, have complete control over any therapy and case management programming. These services, however, were among the least frequently offered, and they rarely carried as high a priority as is typically assigned to "core" services, such as evaluations and in-service training.

Litigation and Jail Mental Health Programs

One increasing approach to remedying deficits in jail mental health services is the class action suit. This

mechanism has been much more common for redress of abuses in State mental hospitals (Harvard Law Review, 1977; Leaf, 1978; Leaf and Holt, 1981) and State prisons (Brodsky, 1982) than elsewhere. Singer (1981) points out that one of the first actions in regard to jail mental health services was a 1971 suit brought by the inmates at the Lucas County, Ohio, jail. In a sweeping decision (Jones v. Wittenberg, 330 F Supp. 707, W.D. Ohio 1971) the court ruled that arrangements had to be made for inmates with "special medical problems," which has been interpreted to include mental health problems. Although this decision is a decade old, the number of local jails that have been sued and the volume of successful cases since 1971 is unknown. The fact that a number of jails in major metropolitan areas such as Philadelphia, Baltimore, District of Columbia, Chicago, Pittsburgh, and San Francisco have had court orders to improve mental health services is apparent from media coverage. However, no systematic work has determined how many court orders have been imposed and whether inadequacies of mental health services in smaller suburban and rural jails have been the source of any successful litigation.

Not only is the volume of litigation uncertain, but its impacts are unclear. Harris and Spiller (1977) followed up three cases involving local jails plus the Arkansas State prison system, and Brodsky (1982) has reported comparative data on the responses of the Baltimore City Jail and the Alabama State prison system. Both these reports suggest some major positive change emanating from the successful court suits. Neither, however, attempted to systematically measure the changes or the persistence of observed improvements after the order or consent decree was concluded. Furthermore, a recent General Accounting Office report (1980) contended that "while court intervention can improve conditions and is necessary in some instances, for several reasons it is not the most desirable solution for every case." This is so, the report argues, because broad-scale change rarely ensues, litigation is by nature reactive, not preventive, and litigation is slow and expensive.

Because of developments in litigation, 3 of the 10 supplemental sites (Las Vegas, Pittsburgh, and Phoenix) were chosen specifically because they were under court order to develop jail programs. In addition, 2 of the 33 jails presented at the NIC conference were also under court order (Janesville, Wisconsin and Louisville, Kentucky). In

four of the sites, mental health services were specific issues in much broader suits. Only in Pittsburgh did the suit and court order center on mental health services alone.

During the course of the site visits, a strong impression developed that in the absence of court orders, very little probably would have changed in the mental health programs for jail inmates. The assistant chief administrator in one of the jails, for example, said that he hoped the court order was never rescinded because it gave him the only leverage he had in securing county appropriations. He believed that without the suit, conditions would not have improved, and that without the decree in effect, the county would back out of existing commitments. This judgment is consistent with the view articulated in a recent New York Times article on evolving roles for Federal courts: "... many officials had confided to the lawyers litigating class action suits that the Federal court lawsuits and orders were the only way they could get legislatures and elected officials to provide for the policies and practices they had wanted to put into effect all along" (Rawls 1982b, p. A21). In another jail where mental health services had been developed over the past year, the mental health program director argued that while some change had been under way, the pending court suit had expedited program development. In a third site the assistant director of the jail stated, "The court forced us to do certain things regarding mental health because of concern with individual inmate cases."

These and other observations suggest that the role of the courts in initiating reform in jail mental health programs may indeed be substantial. The reforms appear unquestionably to contribute to more humane conditions. However, it is unclear precisely what types of changes have occurred, to what extent litigation or the results of litigation actually produced the changes, and, most important, how much of the reform remained or was expanded after the court found the jails in compliance and rescinded the orders. Although our current work on jail mental health programs was not designed to answer these questions, it nevertheless strongly suggests that court intervention is important. Still, it remains unknown if changes in these mental health programs, whether or not in response to judicial intervention, are reflected in the broader community mental health service delivery system. Accordingly, what is needed is a larger sample of jails than previous studies have been able to assemble and more precise

measurement of the changes in mental health programs following court interventions.

Summary

Efforts to improve mental health programming at the sample jails during the year and a half under study met with mixed results. Services at one quarter of the jails did not change at all or actually deteriorated either in quality or in scope. Officials at the majority of sites did succeed, however, in implementing certain improvements, but in many instances the reforms had a relatively modest impact.

The lack of sustained innovation is somewhat surprising in view of the importance of psychiatric services and the numerous deficiencies reported at the time of the site visits. It could well be, however, that overcrowding has at last become so serious that it overshadows all other local correctional concerns. That is, no matter how important mental health care may be, the provision of adequate space and food necessarily assumes a greater priority.

Those sites that had made the most progress in improving mental health care were responding to a variety of forces. One site had always had a reputation for providing excellent inmate services, and the improvements were typical of what many had come to expect there. Another jail reorganized its mental health program following a rash of suicide attempts, while at a third location, a county task force was instrumental in motivating correctional, mental health, and political authorities to take the necessary action.

The role of the courts in facilitating change is not clear. Officials at two sites operating under a consent decree did, in fact, make a great deal of progress. But mental health services deteriorated at another jail despite a court order to revitalize the program, and a court order had no apparent impact at a fourth location. Nevertheless, it is quite likely that more suits will be filed in the future. Services are not being improved at a rate that keeps pace with the rising demand, and inmate-filed suits are becoming an increasingly common phenomenon. In light of this, more research is clearly needed on the court-order implementation process and on what if anything can be done to make that implementation more effective.

CHAPTER VII

PRINCIPLES FOR PLANNING JAIL MENTAL HEALTH PROGRAMS

The preceding chapters have presented our major research findings concerning the organization and delivery of jail mental health services in 43 communities from various parts of the United States. We stated in chapter II that current professional standards offer relatively little guidance in how to design and implement jail mental health programs. Such standards do help local jails identify service requirements as well as help the courts and Statewide agencies monitor the extent to which the jails are meeting those requirements. But the standards can be met in a variety of ways and, as currently written, they offer little practical guidance to county officials and mental health agencies in meeting the needs of mentally ill jail inmates.

In chapter III, we presented information about different approaches and practices that were followed by the 43 study jails in providing mental health services for inmates. Eight basic mental health service components were identified. We found that jails in our study ranged from ad hoc programs, which respond to only the most acute situations without any onsite service capacity, to comprehensive programs involving thorough evaluations, prompt treatment for crisis stabilization, and case management or referral to community agencies upon release.

In our major research focus, as presented in chapter IV, however, we examined the interorganizational arrangements of these programs, especially with regard to the auspices and location of the jail mental health programs. Our findings indicated that no single combination of auspices ("who ran the program") or location ("where the actual services were delivered") was clearly more effective than any other. In one arrangement there was less conflict between agencies, but service and safety goals were not equally well met. In other service arrangements, both goals were effectively met, but interagency conflict occurred more often. In general, we found considerably less conflict between the goals of the mental health staff and the correctional staff than was expected. This was true for both basic program goals and day-to-day operational issues.

In this chapter, we shift from reporting empirical findings to pointing out their implications for the development of jail mental health programs. We do this by setting forth several principles or basic guidelines that need to be considered by local communities as part of the planning and implementation process associated with jail mental health programs. These principles capture much of the rationale and many of the operational features of the better programs we encountered during the course of this study. The principles also incorporate our own best judgments as to how humane and responsive services can be effectively mounted for mentally ill jail inmates. We believe that these principles are generic, in that they can be applied to jails and communities of various sizes and resources.

We should point out that these principles do not constitute a "cookbook" of directives that can be mechanically applied to solve every problem of service delivery in this area. Rather, each county will have to develop the particular implementation details to fit its local circumstances. With the guiding principles discussed below, however, the basic options and strategic choices that must be considered will be more apparent and the mechanisms for successfully achieving the ultimate goals will be more easily devised. There may be no one best way to organize mental health services, but some fundamental decisions that must be made early in the planning process will influence the ultimate success or failure of any initiative in this area.

These guidelines are particularly relevant for communities where the average daily jail population is 500 inmates or less. This includes all but approximately 25 of the 3,500 U.S. jails. The economy of scale of the largest facilities not only permits the implementation of options that would be impossible elsewhere, but it creates a whole new series of service delivery problems--not directly studied in the research reported here--that are seldom found when relatively few disturbed prisoners need treatment.

Planning Principles

To properly deal with the problem of what to do with mentally ill inmates, it is important first to make sure that the issue is considered in the proper context. All too often, primary responsibility for developing a response to disturbed criminals has been delegated to local jail officials, whereas a much broader group of actors is actually required. The

question that must ultimately be resolved is how the community (not simply the jail) can best deal with the problems caused by mentally ill persons who are arrested both for minor infractions, repeatedly in some cases, and for more serious crimes. The jail clearly has an important role to play while the mentally ill persons are in custody, but the development of a comprehensive, satisfactory solution to the problem requires the input and cooperation of other key actors as well. Accordingly, we arrive at principle 1.

Principle 1. The mentally disturbed jail inmate must be viewed as a community issue. The jail cannot be considered an isolated institution in the provision of mental health services. Mentally disturbed persons, on the average, spend very short periods of time in jail. Also, except for the megajails in the major metropolitan areas, it is impractical to consider developing a comprehensive set of mental health services within the jail. Such action is not warranted on the basis of need or in terms of the dollars or physical space available. Jails must make effective use of community mental health centers; psychiatric units of general hospitals; private practitioners; university departments of psychology, medicine, and social work; and State mental hospitals. Effective use does not necessarily mean actually transferring inmates, but it does mean capitalizing on the expertise of the staffs of these programs and planning services in ways that can share program resources.

To establish appropriate services for such persons requires that the jail be seen as only one agency in a continuum of county services. Indeed, some mental disturbance is a function of the incarceration experience, which can be quite frightening and depressing. However, the more common mental health problems are presented by persons whose existing problems are exacerbated by jail or whose current acute episode precipitated their arrest and incarceration. For these persons, the jail is attempting to perform its custodial function of safe pretrial detention while addressing the mental health problems of community members whose access to services is often highly restricted. Obviously, an adequate response cannot be expected if the mental health service needs are defined simply as a jail problem. The jail is a community institution, and the mentally disturbed inmate is a community problem.

Thus, an important first step in responding to these issues may be to convene a meeting of the key actors from

the full range of mental health agencies--public and private--in the county. Clearly, many of the key actors are not interested in or are even resistant to dealing with the clientele of the jail. Nonetheless, if a strategy to address these issues is to be devised, some assessment is needed of how the jail can effectively link up with the ongoing mental health services in the community.

To prepare for such a meeting, at least one other preliminary action should be taken--an empirical needs assessment. Because so much of the interaction between the mental health community and the criminal justice system is precipitated by some single heinous or tragic incident highlighted by the press, crisis responses often neglect the norm. An essential ingredient in planning for jail mental health services is a determination of exactly what the needs are. Some independent clinical assessment of all residents or admissions to the jail over a period of time is critical. Furthermore, it is essential to document what services were actually used in the past year or two, by whom they were delivered, and what they cost. It is not enough for the sheriff to claim that "half of my inmates belong in mental hospitals," nor is it sufficient for the community mental health director to claim that "every inmate we have seen in the past 6 months is too dangerous to be treated in our program." A systematic assessment of actual needs in the past and projections for the future is an essential ingredient in adequately taking this first step.

A good starting point in this endeavor is a review of institutional records to see how many inmates are referred for care every month, how many are currently receiving psychotropic medication, and so on. Surprisingly, very few jails seem to keep such records. Virginia Beach, Virginia, is a clear exception in that officials of the mental health unit must submit detailed quarterly reports and maintain a special log in which the circumstances of every suicide are noted along with comments on the known psychiatric history, if any, of the inmates involved. Elsewhere, however, not only are records seldom kept in this manner, but, when they are, they show major discrepancies with the corresponding documents maintained by mental health agencies. One small jail, for example, reported that 15 inmates were sent to the State hospital forensic unit during 1980, whereas information at the hospital indicated that only 3 had been sent. Administrators at another jail insisted that the mental health center conducted 390 evaluations at the jail in 1980,

whereas the psychologist who actually performed the examinations could remember only about 40. When the mental health chief of a medium-size jail in the Midwest suffered a nervous breakdown, her successor was not even able to reconstruct how many inmates were being treated or what types of treatment they were being given. One jail chosen as a comparison site had to be dropped from the sample altogether because it maintained no program records of any sort.

Another important component of the overall needs assessment is an examination of State and Federal expectations regarding the incarceration of the mentally ill. Many States have promulgated minimum standards for the care of disturbed inmates, and although the standards are often vague or unenforced, they nevertheless represent a potentially significant reference source. Court orders mandating the delivery of certain services will obviously have to be scrutinized as well, and any pending litigation alleging major deficiencies in the mental health program at the jail should pinpoint areas needing improvement even when administrators doubt the overall merit of the case.

Furthermore, it seems useful in the context of such a meeting to highlight the findings presented in chapter V regarding custodial-therapeutic conflict. Contrary to some stereotypical views, correctional and mental health staff can work together effectively. The common mental health view of inherent conflict in such settings does not seem to fit with the circumstances of the contemporary county jail. There are conflicts, of course, but usually inconsequential ones. At the interorganizational level, where key actors are involved, conflicts are apt to be over how many dollars are available and who establishes criteria for admission and discharge. These kinds of conflicts are much more difficult to deal with, but with some understanding of the community nature of these problems, solutions may be forthcoming.

One example of how solutions to jail problems are linked to other components in the mental health system occurred in the Boulder County (Colorado) jail. They had encountered serious problems in finding inpatient beds in the State hospital for jail inmates for whom transfer was strongly indicated. After much pressure, the State responded by allocating a specific number of beds to each of its catchment area counties. Boulder County was allocated 16 to 20 beds to which the CMHC director could make

direct admissions. Because of the close working relationship between the Boulder CMHC and the jail, emergency transfers are now possible so that at any particular time there are usually five or six jail inmates using the Boulder County bed allocation at the State hospital.

Another important group in the community is the judiciary. Judges are frequently called on to rule on applications to transfer mentally ill prisoners to State hospitals or to approve the involuntary commitment of persons who can no longer be cared for by their families. Judges must also select an appropriate disposition for disturbed persons who have just been convicted or who have pleaded guilty to a criminal offense. The range of options includes diversion to a community treatment program, a suspended sentence whereby the person is released without supervision, probation, and confinement to a jail or prison. Finally, judges may have to render a verdict in class action suits alleging that the quality or extent of mental health care at a given jail is unconstitutional.

Judges can thus have an enormous impact on jail operations, but their jurisdiction and their ability to effect lasting change is sometimes weaker than it may first appear. A newspaper editorial at one of the sites, where the jail was operating under a far-reaching court order to improve mental health services, praised the judge's decision in the case but pointed out:

> No judge alone can correct all of the problems and deficiencies that keep arising at the county jail. What is needed is a deep and abiding commitment from the County Prison Board to modern prison management policies and practices, plus the full-fledged support of the county commissioners who control the purse strings of reform.

Thus, it is crucial that top county officials be involved in, or at least be kept advised of, jail efforts to develop mental health programming. However, the support of political leaders may still waver unless the public takes a broader interest in the mentally ill and provides a mandate both to improve correctional services and to explore noncustodial ways of responding to disturbed offenders.

Jail administrators cannot expect to obtain increased funding for mental health services if neither the public nor the county executive understands the gravity of the situation. For example, a task force established to study the mental health program at the Salt Lake County (Utah) Jail recognized this fact and recommended that a broadly based Citizens Advisory Council be formed to work with the mental health center and jail project coordinator. The task force also recommended that community education efforts be increased through the use of newspapers, television, radio, and personal contacts so that local citizens would become more aware of problems stemming from the incarceration of mentally disordered inmates. The chief administrator of another jail held a news conference to highlight the need for better care and gave press photographers a tour of the facility's aging infirmary and isolation cells. His comments resulted in a series of newspaper articles and editorials that ultimately helped to persuade the county commissioners to appropriate funds for a major renovation. In short, the jail cannot be expected to adequately address the mental health needs of its inmates if it is seen as an isolated institution. A productive set of first steps to counteract this perception could be the aforementioned needs assessment and meeting of county officials.

Principle 2. The jail is and should remain primarily a correctional facility. Local adult correctional facilities in the 20th century were designed for the purpose of incarcerating criminal offenders. Padded cells, observation tiers, and other devices that may be used in managing the mentally ill are intended only to help jailers meet the most pressing physical and psychological needs of men and women who cannot be freed to seek professional attention elsewhere. Jails are not meant to be used as a specialized type of mental institution.

Given the importance of caring for disturbed inmates and the frequent inability of officials to transfer such persons to State hospitals, the temptation may nevertheless exist to expand the level of mental health care at the jail to a point at which all but the most psychotic prisoners can be handled internally. Such a concentration of services may seem advantageous in the short run, but there is a serious danger that it will ultimately cause both the police and judges to view the jail as an appropriate place to send mentally ill persons who do not really have to be incarcerated. A physician serving on the Allegheny County (Pittsburgh,

Pennsylvania) Prison Board explicitly warned jail authorities about this likelihood:

> Those of us who have been in private practice have all seen the kind of person you just can't handle due to the extent of their mental illness. If you have a place for them, these people will be sent to the jail without committing any crime. I foresee this happening--imaginary offenses to get these people in there--and we've got to make sure that unless a person commits a criminal offense he just can't go there (Pittsburgh Press 1980, p. A-16).

A similar concern was voiced by members of a task force studying proposals to establish a separate mental health unit at the House of Correction in Milwaukee, Wisconsin. The head of the county's protective services management team stated emphatically, "We don't want to make it better to treat mentally ill people through the criminal justice system than through the mental health system because that's a crime against the people being treated" (Milwaukee Journal 1980, p. 5). Such an arrangement would also make the task of managing the jail more difficult and increase the risk that other prisoners will assault or be assaulted by people who do not have full control over their actions.

Ironically, the practice of sending mentally ill people to jail so that they can take advantage of the services available there can ultimately contribute to a vicious circle, because the jail will need even more resources in the future to treat the increased number of disturbed inmates in custody. If more staff are then hired to accommodate the greater demand for professional care, correctional officials will simply reinforce the community image of the jail as a resource center for the mentally ill who are caught breaking the law. Administrators thus need to adequately protect the welfare of those who must be confined, but if the sole or primary reason for confinement is their need for mental health services, they should not be in local jails.

Principle 3. Serious mental health needs among inmates require limited but high-quality professional services in every jail. Although no one would argue that the county jail is an ideal location for delivering either medical or psychological treatment, certain clear needs must be met. Since 1899, Federal courts have consistently ruled that

correctional officials must provide at least basic medical care (Carrabba 1981). Moreover, the Supreme Court has held that failure to provide adequate treatment constitutes a violation of the Eighth Amendment when it results from "deliberate indifference to a prisoner's serious injury or illness" (Estelle v. Gamble, 429 U.S. 97, 105, 1976).

The leading judicial opinion pertaining to the delivery of mental health services in jails was issued in response to a lawsuit filed on behalf of prisoners at the Allegheny County Jail. In Inmates v. Pierce (489 F. Supp. 638, 1980), a U.S. Circuit Court of Appeals concluded that although most challenges to prison medical care had focused on the alleged deficiencies of treatment for physical ailments, there is no reason why the adequacy of mental health care should not be held to the same standard. In reaching that decision, the court cited Bowring v. Goodwin (551 F. 2d. 3rd Cir. 1978) in which another Circuit Court of Appeals had stated flatly that there is "no underlying distinction between the right to medical care for physical ills and its psychological or psychiatric counterpart." The Court of Appeals concluded that the "deliberate indifference" standard of Estelle v. Gamble is applicable when evaluating the constitutional adequacy of mental health care provided at a jail or prison. The key factor in determining whether a system for providing psychological or psychiatric care is constitutionally adequate is whether inmates with serious mental or emotional illnesses or disturbances are provided reasonable access to medical personnel qualified to diagnose and treat such illnesses or disturbances.

After ruling that jail inmates are, in fact, entitled to receive mental health care, the court remanded Pierce to the U.S. District Court for Western Pennsylvania to consider the specific remedies that would have to be implemented to bring the Allegheny County Jail into compliance with the requirements of the Federal Constitution. Inasmuch as this facility (average daily population of 440) is among the largest jails in the country, many of the changes ordered by the court would probably not be expected of jails that are considerably smaller. The underlying principle that guided the court in selecting those changes, however, is probably equally valid for all local adult correctional institutions:

> The jail is not a mental health facility, nor do administrators intend that it become one. It must, however, be staffed and organized to meet

> emergency situations, to make appropriate referrals, and to carefully care for and protect those who must be housed in the jail for whatever reasons despite their mental illness. (Inmates v. Pierce, 489 F. Supp. 638, 1980)

The issue of staffing is particularly important. The court ruled that whenever the ratio of professional staff to inmates having serious mental health problems constitutes an effective denial of access to diagnosis and treatment by qualified health care professionals, the "deliberate indifference" standard is violated. The exercise of informed professional judgment regarding the serious medical problems of individual inmates under such circumstances is precluded by the patently inadequate size of the staff. One of the first things that the superintendent of the Allegheny County Jail thus had to do to satisfy the terms of the court order was to hire more trained personnel to tend to inmate needs.

It should be pointed out that the limited availability of community resources is no defense against charges of inadequate inmate care. A Federal court has stated explicitly that "lack of funds is not an acceptable excuse for unconstitutional conditions of incarceration" (Finney v. Arkansas Board of Corrections, 505 F. 2d. 194, 201, 8th Cir. 1974), and this argument was rejected in the aforementioned Allegheny County case as well. As long as a county chooses to operate a jail, it must provide specialized care for the health needs of its inmates regardless of taxpayer opposition or other seemingly mitigating circumstance.

But while minimal services are a necessity, the fact remains that the diversion of disturbed offenders who do not pose a serious threat to the public safety might still be a major objective for more appropriate service delivery. The National Advisory Commission on Criminal Justice Standards and Goals (1975), the National Coalition for Jail Reform (undated), and the Advisory Committee on Intergovernmental Relations (1983) have all taken the position that jails are not designed, equipped, or staffed to handle the mentally ill and that incarcerating such persons is inherently unfair in any case. They also note that many communities have had much success in diverting minor offenders.

Most efforts of this sort focus on diverting the mentally ill before they are actually taken into custody. In some

instances, responsibility for diversion has been assigned directly to specially trained police officers. In Galveston County, Texas, for example, a group of sheriff's deputies has been certified as "emergency medical technicians" and received special training in crisis intervention and casework principles at the regional mental health center. The deputies are available around-the-clock to work with mentally ill people encountered by law enforcement personnel (National Coalition for Jail Reform undated).

Other police agencies have chosen to work with mental health professionals who can respond to crisis situations as they occur. Perhaps the best-known model of this type is that developed by Montgomery County Mental Health/ Mental Retardation Services (MCRS) in Norristown, Pennsylvania, which was cited as an "exemplary program" by the Law Enforcement Assistance Administration (LEAA). MCRS is a private nonprofit corporation founded in 1974 to meet the immediate short-term needs of psychiatric and drug/alcohol emergencies on a 24-hour basis. It has a staff of 138 employees and operates a fully accredited psychiatric hospital with 33 beds. When local law enforcement officers encounter a disturbed person, they can call MCRS to request an ambulance with trained mental health counselors, who then treat the person at the scene or provide transportation to a hospital or other appropriate facility (Blew and Cirel 1978). Between February 1974 and December 1982, more than 35 percent of all MCRS contacts were criminal justice referrals. A 3-month study of 152 police referrals indicated that charges were finally brought in only 34 cases (22 percent). The total annual cost for all MCRS services after third party payments is approximately $250,000.

A comparable program, somewhat more limited in scope, is based in Fairfax, Virginia. In 1977, the county Community Services Board established a Mobile Crisis Unit (MCU) to meet emergency mental health needs between the hours of 4:00 p.m. and midnight. The unit provides the police with immediate, on-the-scene assistance for a variety of calls including domestic disturbances, suicide threats, substance-abuse problems, and episodes of acute psychiatric disturbance. In 1979, MCU staff were able resolve the problem without detention in 421 (73 percent) of the 581 cases in which a field visit was made. An evaluation conducted in 1979 found that the MCU reduced the percentage of involuntary detentions by 47 percent over the number of detentions that could have been expected to occur without

MCU intervention. A followup study of patients who were not detained revealed that 71 percent had followed through with referrals and were actively engaged in a voluntary treatment program 4 weeks after the intervention (Fairfax County 1981).

Police officers in counties that do not have mobile crisis teams often have no choice but to arrest a person who is suspected of being mentally ill and who is creating a disturbance. Diversionary efforts at these locations must then take place before sentencing, often while the person is in custody. The locus of such a program may be the district attorney's office, a court clinic, or public defender's office. The Boulder (Colorado) Community Corrections Department has a Pretrial Services Unit with a special bond coordination/supervision program which interviews mentally ill prisoners and refers them for treatment in the community when appropriate.

Programs such as those just described offer humane, cost-effective alternatives to incarceration. Many communities do not have the resources to develop similar services, however, and informants at several sites indicated that the local district attorney would be reluctant to divert known offenders in any case. Even mental health officials occasionally questioned the desirability of diverting mentally ill persons from jail on the grounds that mental illness alone rarely excuses illegal behavior. Thus although diversion can be both effective and appropriate, it does not have universal support. Furthermore, it does not represent a total solution to the current jail mental health crisis since even jails in communities with strong diversion programs already in place report ongoing problems with disturbed inmates who cannot be diverted. Under any circumstances, then, some core mental health services are necessary for jail inmates.

Figure VII-1 depicting the mental health services offered at the detention facility in Contra Costa, California (average daily population of 244), schematically presents an actual model of the type of program we recommend. Efforts to identify the mentally ill go far beyond the simple administration of a screening instrument at intake. Mental health staff accept referrals from a variety of sources and have the capacity to respond promptly to emergency situations. Once inmates have been identified as mentally ill, those who are acutely disturbed are referred to inpatient psychiatric hospitals. Others may be given outpatient care

Figure VII-1. Contra Costa detention facility mental health services

1. Request from deputy in booking or intake module	Mental health staff to booking or intake to evaluate inmate and determine level of service required	Acutely Mentally Disordered (in danger to themselves or others or gravely disabled) Refer to inpatient psychiatric hospital If no beds available, refer to medical/psychiatric module	Community Placement Inpatient psychiatric facilities Residential halfway houses Board and care homes Outpatient clinics Vocational services Monthly followup Prison Referral For continuity of care
2. Early identification of mental disorder through screening within 72 hours	Mental health clinical staff interviews anyone expected to stay at least one week	Mentally Disordered--Unstable Medical/psychiatric unit • 24 hour care • observation room for suicide risk • rubber room • 20-25 beds in single rooms Mentally Disordered and Extremely Dangerous Administrative segregation outpatient services provided by clinical staff	
3. Referrals from: • Court • Deputy • Self • Medical or substance abuse staff	Immediate response or appointment scheduled at earliest convenience	Mentally Disordered--Stable General housing--outpatient services Not Mentally Disordered, But in Crisis General housing--volunteer or staff to provide crisis counseling	

in administrative segregation or in the general population, depending on the extent of their perceived dangerousness. Ancillary facilities, such as a rubber room and observation room for suicidal inmates, are also available for use as the need arises. The hallmarks of this system are promptness and flexibility, which place a premium on inmate management rather than on treatment in the classical sense. Prisoners who still need professional care when they are released are encouraged to accept a community placement appropriate for their particular needs.

Principle 4. Correctional administrators should concentrate their efforts on developing mental health services in the areas of identification, crisis intervention, and case management at release. The research reported here did not set out to analyze the substantive aspects of jail mental health programming. Rather, our focus was to investigate the organizational and interorganizational aspects of service delivery. Nevertheless, it became apparent during conversations with correctional and mental health staff involved in jail mental health programs that many practitioners shared a common view regarding the appropriate function and relative importance of the various service components.

The types of mental health services that are basic for the local jail become apparent from the awareness (discussed in chapter V) that jails are people-processing institutions (Hasenfeld 1972). That is, jails are short-term facilities whose primary function is to hold the inmates pending their disposition (or, more appropriately, to keep them until the court classifies them) for some other organization to handle (e.g., a State prison, county probation, or a pretrial diversion program). Their focus is not on long-term detention and basic personality change or rehabilitation. When the jail is understood for what it is, the mental health services that need to be emphasized become clear.

Accordingly, the three principal mental health needs in planning jail services are identification, crisis intervention, and case management at release. In contrast to what the jail administrators tended to highlight in their program descriptions, this package deemphasizes broader treatment objectives. Almost inevitably, when asked about their mental health program, sheriffs or chief administrative officers related how many hours per week the psychiatrist was in the jail, how many nurses were available to monitor medications, how mentally disturbed inmates had a special

housing tier that facilitated their treatment, and so on. In short, what they tended to discuss was their treatment program. Rarely did we spontaneously hear of a thorough screening program, of the rapid deployment of mental health services for stabilizing the volatile, mentally disturbed inmate, or of linkages with community mental health services upon release.

In contrast to those services centering on treatment, the programs we surveyed that appear to provide the most humane services, while most effectively aiding the jail operation, were those that deemphasized traditional treatment in favor of early identification, appropriate short-term interventions either in psychotropic medications or specialized housing units, and effective collaboration with community resources to maintain persons in the community so that they were not quickly rearrested. The mental health staff at one such program observed that treatment in their jail really meant two things: (1) "helping people deal with the reality of their incarceration" and (2) "getting the inmates in touch with themselves to be able to recognize their problems and agree to seek care upon release."

Clearly, such program priorities do not supplant the need for professional psychiatric attention to individual inmates. Unless mentally disturbed, acting-out inmates are identified at an early stage, serious injury to staff and other inmates or to themselves may occur. However, for such inmates or for less seriously disturbed inmates, psychiatric treatment in the classical sense of individual or group therapy sessions is not feasible, given the jails' functions. The prescription of medication and recommendations for special housing tiers, when available, constitute the limits of appropriate treatment in such cases.

Just as identification may be seen as an ingredient of the treatment program, so, too, may case management. A report on jail services at the Milwaukee House of Correction concluded, "Teaching our short-term inmates where to go for help is frequently more important than treating them ourselves." Two of the facilities in our study tackled this problem by having mental health staff split time between the jail and community agencies. In Contra Costa, a psychiatric resident rotates through both the jail and the CMHC during her weekly duties. Inmates can thus be seen by the same service provider while in custody and following release. Prisoners are considered more likely to follow

through on their appointments if they know in advance whom they will be dealing with and have already had an opportunity to develop a working relationship. Similarly, part of the mental health staff in the Boulder County (Colorado) Jail is actually on the CMHC payroll and assigned for a specified number of hours per week to the jail primarily for screening and case management.

Case management need not, of course, be limited to making appointments with specific mental health professionals. If an inmate is on psychotropic medication, the jail psychiatrist may want to call a pharmacy to ensure that there is no lapse in the prescription. In Contra Costa, the jail provides transportation to a halfway house if it is deemed appropriate by the medical or social service staff. Job placement services can also be very helpful, because two-thirds of the mentally ill offenders identified in one study were unemployed at the time of their arrest (Arthur Bolton Associates 1976).

A case management service can be structured in several ways. Some jails refer all mentally ill prisoners who need continued care to community agencies. Facilities with more limited staffing resources may have to limit referrals to a particular subgroup of the mentally ill, such as those on medication or those who are involved in a therapy program. Although mental health professionals should obviously have an important role in deciding the specific nature of the referral, the person who coordinates the program can be a correctional officer or member of the social service staff. This flexibility exists because boundary-spanning activities require more organizational and communication skills than actual clinical experience. One of the coordinator's most important tasks, for example, is to assess existing community resources to determine the agencies' service eligibility requirements and overall organizational goals.

One method of addressing this concern and simultaneously enhancing the continuity of care is to have mental health center staff who are called in to evaluate an inmate at the jail make an appointment to see the inmate after release. Such an arrangement is already in place in Lawrenceville, Georgia, and seems to be working well. Another way of providing the service to give mental health primary emphasis has been implemented in Salt Lake City, where the mental health center has assigned employees to work full-time at the county jail. The counselors not only make an

appointment for inmates to receive further care from appropriate community agencies upon release, but they also give the inmates the telephone number of the jail mental health unit and encourage them to call back in the event that they have any difficulties in obtaining the recommended care.

Jail officials may be frustrated in their efforts to develop a good case management program by the lack of community resources capable of providing aftercare services. The U.S. Department of Justice specifically raised this issue in its defense against criticism from the General Accounting Office concerning the way in which inmates were released from Federal detention centers (Rooney 1980). Also, in a recent review of 129 mental health halfway houses, only 9 expressed a willingness to serve offenders (Goldmeier 1977); the lack of resources is reported to be particularly acute in rural areas (Harding and McPheeters 1979; Kirk and Spears 1979).

If the jail concentrates on developing these core services of identification, crisis stabilization, and case management and makes no pretense about its intent or ability to treat the mentally ill, judges may be less inclined to send a disturbed individual to jail for the sole purpose of receiving specialized care. In the absence of community alternatives, the police may still use local correctional facilities to detain mentally ill offenders who do not need to be incarcerated. Jail services should not, of course, be developed to a point at which money that is best allocated to community mental health centers is actually being spent at the jail. One of the correctional officers with whom we spoke even mentioned somewhat wryly that if the National Institute of Corrections really wanted to improve the jail's position vis-a-vis the mentally ill offender, it should use its influence to lobby for better funding of mental health centers. In sum, jail services should be designed to help inmates cope with the stresses of incarceration; efforts to address the broader goal of long-term treatment are best reserved for other agencies in the community.

Principle 5. There is no one best way to organize a jail mental health program. Jails can accomplish the objective of protecting inmates' mental health in a variety of ways. In fact, an approach that is both desirable and feasible at one location may be totally inappropriate somewhere else. Different strategies are needed because county jails vary so

greatly in size, structural characteristics, level of perceived need, and resources available in the community's existing mental health service network. Even jails that house a comparable number of disturbed inmates and are architecturally similar may have widely disparate funding bases and different types of mental health agencies in the community that are willing to serve jail clients. The director of the CMHC at one site, for example, absolutely refused to provide professional assistance for inmates. He argued that because most disturbed inmates' needs existed long before their arrest and none had ever bothered to seek treatment in the community, they had no right to expect special attention once they were in custody.

In view of the fact that a jail is seeking to distribute its available resources to emphasize identification, crisis stabilization, and case management, no single arrangement can optimize these services. Whether to establish a contract with a local group medical practice for all mental health services, to enter into a shared staffing arrangement with the local CMHC, or to hire full- or part-time staff on the jail payroll is a decision that depends on a host of historical, political, fiscal, and community factors. This decision also depends on the relative amount of conflict or coordination problems with which the jail administration is willing to deal. As we noted in chapter IV, certain linkages tend to produce more conflict and coordination problems between jails and mental health agencies, while others decrease effective service delivery but reduce conflict.

Each jail should find its solution to the problem of how best to arrange services by carrying out the actions listed in principle 1. The process of first identifying the persons in the community who would be most appropriate to discuss jail mental health services and then analyzing programming issues should provide the basis for identifying the best service structures for a jail.

Some sample sites have done this very well. Most prominent, perhaps, is the sheriff of Colfax, Washington, who even managed to win a seat on the mental health center board of directors to ensure that the jail's needs would be taken into account when the board met to establish annual priorities. Jail officials at most locations, however, make plans for program services much more informally and suffer somewhat predictable results. A task force assembled at one large eastern city commented: "The county mental

health/mental retardation system is unclear as to what its role should be with regard to the jail. Most base service units who have clients at the jail are uncertain what their responsibilities are." A report on service delivery at a large western jail similarly noted: "There is no written statement of responsibility for the mentally ill inmate. Verbal agreements between the sheriff and public mental health have been both confusing and misleading as to which agency has follow-through responsibility." The research committee of a task force on mentally ill criminal offenders at a third site declared: "The population at issue has not been defined, the magnitude of the need is unknown, and the needs are essentially unassessed. Service providers and officials at neither the jail nor the county mental health system understand the workings or limitations of either system." The conclusion is that there must be appropriate linkages between the jail and existing mental health providers in the community. Exactly what form these linkages take depends on both the wide range of resources available and the goals of the county for the jail's mental health program.

A Regional Mental Health Approach?

Jails in rural counties tend to be especially hard-pressed in finding ways to manage the mentally ill. The local tax base is usually very limited, and sometimes no area hospitals or mental health agencies are willing and able to help. One solution may be the formation of a mobile mental health team which visits several rural jails on a regular and as-needed basis to evaluate prisoners and provide whatever treatment is possible. Some jails in our study were already doing this with apparent success.

Another way of assisting these facilities may be to designate a regional jail for disturbed inmates who cannot be managed elsewhere. The jail would have an observation unit, padded cells, and an infirmary. Staffing would be provided by specially trained correctional officers and psychiatric nurses. Treatment services would still be limited primarily to crisis intervention so that the jail is not confused with a mental hospital, but at least the inmates would be housed in a secure, nonthreatening environment.

Three types of inmates could ideally be transferred to such a jail. The first is that group of mentally ill prisoners who can no longer be safely managed at the jail where they were initially housed. A second group consists of inmates

who have just been discharged from a mental hospital and who must now be returned to the custody of a sheriff. Correctional administrators complain that the condition of these inmates often deteriorates, so that the regional jail could serve as a kind of halfway house until it is determined that the inmate is fully stabilized. Finally, the jail should be able to accommodate any disturbed female prisoner who is being held in the catchment area. Even some of the larger urban jails in our sample were often unable to meet women's needs in the same way that men's needs were met because of unavoidable structural limitations (the infirmary could not be partitioned to serve both sexes, the observation tier was located in the men's wing, and so on).

Precedent for a regional jail can be found in the practice of some sheriffs to send all female and juvenile prisoners to other counties where the jail has separate facilities for them. In New York, the State Office of Mental Health operates a facility on the grounds of the Central New York Psychiatric Center for jail inmates from 16 counties with acute mental health needs. Each jail provides its own transportation and pays a prorated fee for security expenses to Oneida County, where the center is located.

The successful operation of a regional jail that handles mentally ill prisoners would obviously be predicated on the development of clear lines of clinical and administrative authority. The criteria for transfer would also have to be understood and accepted by all concerned so that the jail does not become a depository for all disruptive inmates. Other problems such as those stemming from a possible change of venue would have to be worked out. Responsibility for administering the mental health unit could be assigned to at least three different actors. Many respondents in our sample, for example, believed that the mental health system should take the initiative. Others argued that local law enforcement agencies are now being given a higher priority than county mental health centers, so that any arrangement of this sort would be more likely to receive funding under the guise of corrections. Still others pointed out that intercounty cooperation has historically been extremely poor and that no sheriff would agree to have such a unit in his jail in any case. The Lancaster County (Pennsylvania) forensic services task force therefore recommended that the State establish a regional forensic psychiatric facility similar to the one in New York. Consistent with the "no one best way" concept, officials in each locale will have to

review the advantages and limitations of each approach and decide which seems to make the most sense for them. Nonetheless, the concept of regionalized jail inmates from rural counties of modest size is a concept that warrants close examination.

Implications for Practice and Research

The research we have presented in this monograph was geared towards producing some basic organizing principles for developing jail mental health services. Our goal was to offer some fundamental guidelines that could be put into practice. In many ways, the five major principles we have discussed in this chapter are probably less concrete and can be implemented less directly than jail administrators would like. However, a research effort such as this should not be expected to deliver more specific directives. The range of jails and unique sets of community problems and relationships require the application of general principles to specific circumstances. Although such an approach does not offer specific steps to develop jail mental health services, the guidelines presented, if followed in the general order discussed here, can provide excellent strategic guidance to anyone (jail administrator, county executive, or community advocate) wishing to systematically improve what are often horrendously inadequate services.

In fact, the primary use of these principles may be to alert the planners or initiators of new mental health services to the strategic decisions that must be made. Rather than focusing on questions such as what type or how many staff are needed, whether it is more cost-effective to contract for services, or where the budget items should be placed, we have become aware of what appear to be the overriding questions and assumptions that must be addressed at the outset and from which the specific practices would flow.

It should also be apparent that a core ingredient to developing appropriate services is better information. The planning process requires detailed data on the levels of need in the jail as indicated by previous use of services and current clinical assessment. It requires a comprehensive mapping of the mental health services in the community: how they fit together (if they do), how they are financed, and how they are linked to the social welfare and educational systems, especially higher education and professional

schools. In short, the jail cannot develop mental health services in a vacuum. Even the smallest counties have complex sets of working relationships. Unless some initial reconnoitering is done, the most effective and least costly approaches may be overlooked. Research at the outset of service development or overhaul is critical, as is some periodic feedback about how the service arrangements are working. This type of information is essential to good jail operation and may be imperative if any litigation occurs.

In the end, it should be kept in mind that although we have mentioned many positive features of the 43 jails we visited, the level of care at the sample jails was often inadequate in both scope and quality. This finding is particularly alarming in light of the fact that mental health services at these facilities are probably much better than what would be found in a random sample of U.S. jails. As noted in chapter I, 33 of the sites were represented at training workshops where participants learned a variety of skills pertaining to the planning and implementation of mental health services. The supplemental sites were selected on the basis of their reputation for offering exceptional inmate services or the introduction of a variety of reforms as a result of judicial intervention. As such, all the counties visited had demonstrated an interest in inmate mental health needs that probably far exceeds the norm. Moreover, most American jails are much smaller than those included in the sample, and small facilities tend to be the least able to provide services of any kind. Thus, there is every reason to believe that the quality of mental health care in our nation's jails is as problematic today as it was 10 years ago, when concerns were first expressed about the welfare of deinstitutionalized mental patients who might wind up behind bars. Our hope is that the guidelines that emerged from this research may help communities to more effectively address these acutely serious problems.

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APPENDIX

List of Participating Sites

Location	Facility	Sheriff (1981)
Akron, OH	Summit County Jail	David Troutman
Albuquerque, NM	Bernilillo County Detention Center	Michael Hanrahan*
Billerica, MA	Middlesex County Jail and House of Correction	John Buckley
Biloxi, MS	Harrison County Jail	Howard Hobbs
Binghamton, NY	Broome County Jail	Anthony Ruffo
Bloomington, IL	McLean County Law and Justice Center	Steven Brienen
Boulder, CO	Boulder County Jail	Barbara Gigone*
Burlington, VT**	Chittenden Community Correctional Center	Philip Scripture*
Canton, NY	St. Lawrence County Jail	Keith Knowlton
Calhoun, GA	Gordon County Jail	Pat Baker
Colfax, WA	Whitman County Jail	Cleve Hunter
Colorado Springs, CO	El Paso County Jail	Harold Davis
Columbus, IN	Bartholomew County Jail	Michael McCoy
Concord, NH	Merrimack County House of Correction	William Potter*
Dothan, AL	Houston County Jail	A.B. Clark
Doylestown, PA	Bucks County Rehabilitation Center	Arthur Wallenstein*
Evansville, IN	Vanderburgh County Jail	James DeGroote

Location	Facility	Sheriff (1981)
Fort Collins, CO	Larimer County Detention Center	James Black
Fairfax, VA	Fairfax County Adult Detention Center	Wayne Huggins
Greely, CO	Weld County Jail	Harold Andrews
Hyannis, MA	Barnstable County Jail	John Bowes
Janesville, WI	Rock County Jail	Fred Falk
Lancaster, PA	Lancaster County Prison	Thomas Schlager*
LaPorte, IN	LaPorte County Jail	Jan Rose
Las Vegas, NV	Clark County Jail	Paul Bailey*
Lawrenceville, GA	Gwinnett County Jail	W.J. Dodd
Louisville, KY	Jefferson County Jail	Richard Frey*
Milwaukee, WI	Milwaukee County Detention Center	William Klamm
Milwaukee, WI	Milwaukee County House of Correction	Franklin Lotter*
Newark, NJ	Essex County Jail	Albert Collier*
New Haven, CT**	New Haven Community Corrections Center	Victor Liburdi*
Napa, CA	Napa County Jail	Brenda Hippard*
Orange, TX	Orange County Jail	E.L. Parker
Phoenix, AR	Maricopa County Detention Center	P.L. Severson*
Pittsburgh, PA	Allegheny County Jail	James Jennings*
Port Washington, WI	Ozaukee County Jail	Fernando Perez

Location	Facility	Sheriff (1981)
Raleigh, NC	Wake County Jail	John Baker
Richmond, VA	Henrico County Jail	James Turner
Salt Lake City, UT	Salt Lake County Jail	Peter Haywood
Schenectady, NY	Schenectady County Jail	Bernard Waldron
Sherman-Denison, TX	Grayson County Jail	Jack Driscoll
Shreveport, LA	Caddo Correctional Institute	Carl Hammonds*
Virginia Beach, VA	Virginia Beach City Jail	S.J. Smith

* Chief Administrator; the facility is not operated by a county sheriff.

** New Haven, CT, and Burlington, VT, are the functional equivalents of local correctional centers but cannot be technically described as jails because they are operated by state agencies. Burlington was included because the superintendent had sent representatives to a NIC training workshop in 1978; thus it was one of the original 33 sites. New Haven was a supplemental site because of its status as an NIC area resource center and its reputation for having high-quality inmate services.

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